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ABSTRACT

This document contains the 42 reports from mini-conferences held in various nationwide locations prior to the 1981 White House Conference on Aging. Each report presents an overview of the topic, descriptions of particular problems, and statements of recommendations, based on the views of mini-conference participants, and made available to the official delegates to the 1981 White House Conference on Aging. A table of contents provides a list of the reports by number. The subsequent materials focus on the following topics: energy equity, long-term care, alcoholism, physical health, mental health, age stereotyping, lifelong learning, housing, minority/ethnic groups, diseases, religion, legal services, veterans, transportation, advocacy and consumer protection groups, and existing local/state/regional/national service-oriented programs for the elderly. (NRB)

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WHITE HOUSE CONFERENCE ON AGING, 1981:
Reports of the Mini-Conferences, MCR 1-42

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Papers presented at the White House Conference on Aging, Washington, DC, November 30-December, 1981.

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the 1981
White House
Conference
on
Aging

Report of the Mini-Conference on Energy Equity and the Elderly

MCR-1

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

ENERGY EQUITY

National Retired Teachers Association and
the American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20049

Boston, Massachusetts
October 23-24, 1980

St. Petersberg, Florida
October 29-30, 1980

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Energy Equity

Preface

In October, 1980, the National Retired Teachers Association and the American Association of Retired Persons convened a White House Conference on Aging, Mini-Conference on Energy Equity and the Elderly. One meeting was held in Boston, MA, emphasizing cold climate concerns and another in St. Petersburg, FL, addressing hot climate concerns. The conferences developed recommendations on five energy-related topics: Housing, Economics, Meaningful Roles (Employment and Volunteer Opportunities), Health, and Social Services. One hundred experts from aging, government, energy, and academic organizations participated. Numerous creative and coordinated approaches to mitigate the problems were suggested. Some of the major recommendations are to:

- Eliminate discriminatory practices in eligibility requirements for energy assistance programs.
- Provide employment opportunities for older persons in the energy field by removing a variety of barriers that discourage participation.
- Coordinate energy assistance programs at the local level to ensure a one-stop shopping approach for the elderly who wish to apply for assistance.
- Improve and expand outreach activities associated with energy benefits programs to ensure that those elderly in greatest need receive services.
- Provide increased funding for energy programs, ensure that energy programs reflect specific needs of states, and develop new programs to help elderly pay their fuel bills.
- Earmark funds for applied research on the medical, social, and economic impacts of rising energy costs on the vulnerable elderly.
- Provide incentives to encourage participation of volunteers in a variety of energy programs.

The meetings were funded by NRTA-AARP, the Community Services Administration, the Department of Energy, and the Social Security Administration. Seventeen leading organizations served on a Program Advisory Committee, which helped design the materials and agenda.

The recommendations in this report represent the concensus of opinions of the delegates participating in the mini-conference but do not necessarily reflect the views of NRTA-AARP, the convening organization, or the government agencies that funded the project.

Energy Equity and the Elderly: Introduction

Rising costs of energy have become a pervasive problem for older Americans, pushing up the prices they pay for food, shelter, and clothing, eroding purchasing power, and forcing many older people to pay larger percentages of their incomes for fuel. Federal figures on energy costs document the problem. From 1972 to 1979, fuel costs increased 197.3 percent, three times the rate of other costs in the Consumer Price Index.[1]

These cost increases have caused hardship for the 35 million Americans, including millions of elderly people, whose incomes are below the poverty level.

Resolutions

The following sections contain the resolutions that were developed and adopted by the delegates at both sessions of the Mini-Conference. Because of the page constraints defined for this report, the resolutions from the two sessions have been consolidated and abbreviated.

The resolutions are grouped into five basic categories: Economics, Social Services, Health, Housing, and Meaningful Roles (Employment and Volunteer Opportunities).

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[1] Hearing before the Subcommittee on Human Services, House Select Committee on Aging, August 28, 1979.

Economics

Americans receiving middle-level incomes spend approximately 10 percent of their resources for energy bills, while low-income families pay 15 to 30 percent.[2] Government data show that in 1978 on a national basis, low-income households including the elderly poor were spending 17.8 percent of their income on household energy. Projections indicate that in 1980, poor householders will spend at least 20 percent of their income directly for household energy and, in some regions of the country, their expenditures for energy will be more than 30 percent of their incomes.[3]

An estimated 5.2 million households headed by persons 65 years or older fall below the poverty line set by the federal government, which in January, 1980 was $3,600 for a single person living in a city. Millions of other elderly householders live on incomes above the poverty line but substantially lower than the average income of the rest of the population.

Resolution Topic: Economics

Description of Problem: Inequitable Money Transfer Systems

The millions of low- and moderate-income elderly, whose income sources have not kept pace with inflation, must endure extraordinary hardships because of the high and rising interrelated costs of energy and housing.

Statement of Recommendation: Therefore be it resolved that:

There should be a major re-examination and reform of the existing welfare or income transfer system in order to create a more equitable and realistic level of income for elderly Americans and to reduce the negative impact of rapidly rising energy and related housing costs. The following items should be carefully considered:

1. Raise the benefits in the existing welfare and social systems to realistic levels (e.g. not less than the BLS Lower Living Standards);
2. Enact refundable tax credits for middle-income elderly;

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[2] Hearing before the Subcommittee on Human Services, House Select Committee on Aging, August 28, 1979.

[3] Low Income Energy Assistance Programs: A Profile of Need and Policy Options, July 1980, U.S. Department of Energy.

3. Create a realistic cost-of-living add on to Social Security and other retirement insurance programs to reflect regional heating and cooling differences.

4. Remove financial and program eligibility disincentives incurred by elderly persons who share housing or reside with friends or relatives.

5. Encourage employers to phase-in the retirement of employees, hire elderly persons (part- or full-time) and otherwise help the elderly in maintaining earned income (without concommitant disincentives by the government);

6. Expand weatherization programs to include free replacement of heating units and other related equipment; and

7. Increase tax exemptions (e.g. sales taxes, real estate taxes, etc.).

Description of Problem: Need for Direct Assistance to the Elderly

Increasing costs have forced many older people to cut back on the necessary heating and cooling of their homes. Rising costs also inhibit the purchase of medicine, clothing, food, and appliances. Deprivation of basic needs not only causes adverse physical conditions, but creates stress, anxiety, fear, and depression and restricts social involvement that is basic to mental health.

Statement of Recommendation: Therefore be it resolved that:

1. The Federal government must create a fuel assistance program that gives priority to the elderly. It should be funded at an adequate level and directed at those with low- and moderate-incomes. Income guidelines should include a medical costs factor, and eligibility standards should be structured so as to reflect actual income at the time of assistance.

2. Fuel assistance programs funds should be provided on a multi-year or permanent basis instead of on an interim one-year basis. Program guidelines should ensure: coordination among national and state agencies; consideration of area-specific needs for cooling, heating, and transportation; the increased involvement of state governments in the design and implementation of programs in order to reflect each state's particular needs.

3. Federal assistance should be supplemented by other energy programs including: a) lifeline or block rate schedules, b) fuel and utility stamp program funds, c) direct monetary assistance through state agencies, d) energy clinicians to train older persons and service providers in energy use and conservation, and e) tax credits toward the purchase of necessary health-maintaining appliances (e.g. air conditioners, heaters, and microwave ovens).

4. A consumer price index reflecting the special problems of the elderly should be formulated.

5. Income transfer programs should be examined and modified to reflect variable cost-of-living standards.

6. Federal taxation and expenditures should be adjusted in keeping with the rapid growth of the aged population.

Description of Problem: Unjust Discrimination in Energy Assistance Eligibility Criteria

Single-person, elderly households are subject to unjust discrimination through income eligibility requirements of existing energy financial assistance programs. For example, under the Low-Income Energy Assistance Program, single-person households with an income substantially less than two-person households will receive less financial assistance, even though their energy needs are comparable.

Statement of Recommendation: Therefore be it resolved that:

Discrimination against single persons in assistance laws should be identified and eliminated.

Description of Problem: Need to Evaluate Home Energy Supplier Practices

Home energy supplier practices and policies often have not adequately considered the impact of rising energy costs on elderly consumers.

Statement of Recommendation: Therefore be it resolved that:

1. Energy suppliers should evaluate rate structures that pertain to the elderly, and consider lifeline rates, conservation rates, etc.

2. Regulatory agencies must consider the special needs of the elderly when making rate decisions.

3. The regulated energy industries should provide significantly more counseling for elderly persons in the wise use and management of energy.

Social Services

Many older persons depend upon a variety of social services to fill some of their basic needs -- transportation, meals, emergency fuel assistance, health examinations, and social gatherings with their peers. Measuring the impact of rising energy costs on these social services is difficult. A national organization representing volunteer groups across the country conducted a survey early in 1980 attempting to assess the impact of energy prices on volunteer work, and published the results of its findings.[4] Some of the results of the survey included these:

1. A decrease occurred in the number of people volunteering and the decline was not caused by normal seasonal variations.

2. About 90 percent of the volunteer groups believed the drop resulted from higher costs of gasoline or periodic gasoline shortages.

3. The groups reported a drop in the number of volunteers willing to use their own cars.

The organization that made the survey expressed concern about the scarcity of facts on the effects of energy costs on volunteerism. "It is perhaps most distressing to note that not very much is known about this problem," a spokesman said. "If agencies are seeking out their drop-out volunteers they don't seem to be asking direct questions about the reasons they quit."

Gasoline costs have caused serious difficulties for many older persons who need transportation. Many of them have reduced sharply their travel by car. However, unlike others who can simply increase their use of public transportation to reduce gasoline consumption, many older persons depend heavily on their automobiles. Approximately 7.4 million older adults and handicapped persons experience some physical problem in using public transportation, according to a study conducted in 1979 by the U.S. Department of Transportation.

Resolution Topic: Social Services

Description of Problem: Increased Costs of Social Services Delivery

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[4] Newsline, a bimonthly publication of Volunteer: The National Center for Citizen Involvement, May-June, 1980.

Increasing energy costs for social services have caused cutback of and increased costs for essential services to the elderly.

Statement of Recommendation: Therefore be it resolved that:

When appropriating funds for social services and health care programs, Congress should consider increases in operation and transportation costs experienced by service providers as a result of increased energy costs. Congress also should consider the development of health care and human resource programs and the special accessibility problems experienced by the rural elderly.

Description of Problem: Need for Improved Program Planning and Development

Present social service programs often fail to adequately address the elderly's energy-related problems.

Statement of Recommendation: Therefore be it resolved that:

1. Local service consortiums comprised of program providers and elderly consumers should be funded and organized.

2. Federal program evaluation and subsequent program planning efforts should emphasize coordination.

3. Emergency energy mobilization plans should be developed in conjunction with the disaster plans currently mandated under the Older Americans Act.

4. Long-term local planning efforts should strive for community-wide application of conservation and renewable energy technologies.

5. Technical assistance, emphasizing cost-effective technology, should be available to communities to help them develop alternative energy sources. Senior citizens should be extensively utilized as employees and volunteers.

6. The administrative and operational regulations of the projects should be flexible and recognize each locality's uniqueness.

Description of Problem: Fragmentation of Energy Assistance Programs

Existing energy assistance programs are complex and poorly coordinated. This fragmentation results in increased costs, duplication of services, limited accessibility, and client frustration.

Statement of Recommendation: Therefore be it resolved that:

1. All levels of government should be encouraged to: simplify and consolidate aging-related energy programs through revision of governmental regulations; provide better planning and coordination among agencies administering programs; require co-location of services building on the one-stop shopping concept; provide expanded and more effective information and referral services; and mandate and adequately fund outreach programs to the elderly.

2. HHS, HUD, Community Development Block Grants, Title XX, Older Americans Act, ACTION, CETA, weatherization and other DoE programs, and Farmers' Home Administration should require coordination linkage and review of state and local plans. Applications and proposals for federal funding review should be done by the chief local elected official(s).

3. Federal funds from these programs should be used to pay for planning.

4. There should be incentives in the form of increased Federal allotments for integrated energy services for the elderly.

5. DoE and a subcommittee of the White House Conference Domestic Council should be authorized to review coordination and linkages at the Federal level.

6. The government unit closest to the people being served should control the program whenever possible.

7. For a period not to exceed three years, Congress should authorize that the Low-Income Energy Assistance Program be administered through state block grants, thus reducing fragmentation substantially. The Weatherization Assistance Program, the Community Development Block Grant Program, and state energy assistance programs should be coordinated under the auspices of the agency administering LIEAP. As part of the guidelines for administering the program, the states must: a) ensure the development and implementation of quality weatherization, conservation, and retrofit programs; b) make provisions to ensure local coordination of relevant social services; and c) develop local plans to ensure broad-based energy assistance information dissemination and outreach, and ideally, ensure that these costs are borne through a partnership of public and private agencies.

Minority Opinion:

There must be a clear and ongoing Federal role in these programs, even if they are administered through block grants. Federal agencies should assist with problem solving, information sharing, and the monitoring of state activities to ensure that the interests of the target populations are addressed.

Description of Problem: Need for Outreach/Education Programs

The elderly's awareness of available services must be increased. Many elderly are unaware of services that are available to them. Others, who know of these services fail to take advantage of them because of the programs' "welfare" stigma.

Statement of Recommendation: Therefore be it resolved that:

1. Public funds should be used to purchase broadcast time on radio and TV and space in newspapers in order to educate the elderly about the availability and use of energy services.

2. A corps of trained and informed volunteers should be organized to help other elderly with energy-related problems. Funding for such a program might come from energy providers as well as government at every level.

3. Community education programs located in the Agricultural Extension Service, community colleges, etc. should be encouraged to offer programs and conduct workshops for the elderly on housing-related energy services.

4. Existing networks should be used to operate outreach programs for the elderly. These networks could include: university extension services; energy extension services; utility companies; community, school, civic, and other membership organizations; mayors; churches and synagogues; and radio and TV public service announcements.

5. Energy providers should be encouraged to schedule neighborhood-based seminars for elderly people to explain the most efficient use of heating and cooling appliances as well as weatherization techniques.

6. The Federal government should prepare useful, eye-catching educational materials on government energy services and include them with Social Security checks.

7. The Elderly Outreach Fund program (available to national organizations on aging under Title III of the Windfall Profits Tax) should be increased from $3 million funding.

8. Information and referral services currently operated by state and local agencies on aging should incorporate references to energy services.

9. Information and training should be combined with a home energy audit and made available through the Residential Conservation Service.

10. Clients' privacy should be protected in all assistance programs.

Description of Problem: Lack of Consumer Information

Elderly consumers lack adequate information and education, political cohesion, and a general understanding of the impact of energy decision-making.

Statement of Recommendation: Therefore be it resolved that:

The appropriate authorities or agencies encourage: more dialogue between energy suppliers and the elderly; closer relationships and cooperation between the major and small energy suppliers; representation by the elderly poor on energy agencies' advisory groups; and economic education and clarification of the issues and needs of the 1980's.

Description of Problem: Need for Increased Consumer Protection

Some consumers have been duped by fraudulent and inefficient devices that are promoted as saving energy in one's home, car, or business.

Statement of Recommendation: Therefore be it resolved that:

1. Better regulation of the new energy industry must be developed, and this should include self-policing within the industry.

2. New devices should be more fully tested before they are marketed, although businesses should not be overburdened by rules and regulations.

3. Educational programs should be offered about performance, efficiency, and safety of energy devices for consumers (e.g., through Consumer Reports, Better Business Bureaus).

4. Warranties, guarantees, and other forms of consumer protection should be available to consumers who purchase energy devices.

Description of Problem: Poor Transportation Systems

Many older people lack access to transportation and this causes such problems as: 1) illness or poor health, because some elderly cannot reach doctors' offices, public health clinics, and drug stores; 2) nutritional deficiencies, because the elderly cannot easily get to grocery stores, nutrition sites operated through Area Agencies on Aging, and food stamp centers; 3) mental health problems due to isolation and curtailment of social activities; 4) pedestrian accidents and exposure to inclement weather when older people must walk to reach services; and 5) curtailment of volunteer activities.

Statement of Recommendation: Therefore be it resolved that:

1. Tax credits should be offered to transportation systems (buses and taxies) that offer discounts to elderly passengers and providers.

2. Cities should provide more comprehensive transportation services to meet the special needs of the elderly.

3. More Federal and state funds should be allocated for transportation to medical services.

4. More neighborhood physical and mental health clinics should be established.

5. In programs using volunteers, a higher rate of mileage reimbursement should be offered for volunteer transportation as opposed to staff travel.

6. Programs should be implemented that promote effective utilization of existing and proposed transportation resources. These should call for: revision of existing government rules and regulations to allow more flexible utilization of transportation at all levels; common location of services for cost effectiveness; cooperation between the private and public sectors to expand services; recognition that transportation for social services programs (as they relate to the needs of the elderly) is essential; expense reimbursement for volunteers who transport older persons to essential services; and correction of the rural-urban disparity regarding the availability of transportation services.

Health

Rising costs of energy can affect the health and life styles of older persons. For example, if elderly persons lower room temperatures in winter, they run much higher risks than younger people that they may suffer accidental hypothermia, a sudden lowering of deep body temperature. The condition can be fatal if not treated. If the elderly lack air conditioning in summer heat waves or they reduce cooling levels, they are more likely to suffer fatal heat stress.

Approximately 35 percent of the people 65 years and older have at least one serious illness, such as cancer, heart disease, stroke, arthritis, or a respiratory ailment.[5] For older persons with such conditions, even temperatures below 65 degrees can endanger their health. Additionally, a study of elderly householders showed that as monthly energy costs rose, older householders spent less of their incomes on prescription medicines.[6]

In some cases, terminations of energy supplies because of nonpayment of bills have seriously damaged the health of elderly persons. In some areas, energy companies have adopted policies against termination of services to residential users in an effort to avoid such injury to the health of low-income people.

Resolution Topic: Health

Description of Problem: Need for More Local Initiatives

Medical, social, and economic problems are exacerbated by higher energy prices, particularly among older Americans.

Statement of Recommendation: Therefore be it resolved that:

1. Utilities must be made aware of the importance of their accountability, especially to the elderly poor on fixed incomes. Federal laws should be established to ensure such accountability so that the health of the elderly will not be impaired.

2. Local energy clinics should be established to provide counseling services (by local volunteers) in health-related matters affecting the elderly poor.

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[5] Hearing before the U.S. House Select Committee on Aging, April 8, 1978.

[6] Hearing before the U.S. House Select Committee on Aging, April 8, 1978.

3. Short-term medical contingency programming should be required at the local level, and an early-warning system should be organized to help identify those who are most vulnerable.

Description of Problem: Need for Health Research and Service Programs

The elderly's reduced energy consumption often has a profound effect upon their health and comfort. Stress-related illnesses and physiological disabilities combine with inappropriate energy-consuming lifestyles to contribute to serious health risks.

Statement of Recommendation: Therefore be it resolved that:

The Federal agencies concerned should be required to: 1. Disseminate to the elderly and their families, useful information on how energy conservation can be accomplished in a manner that is non-injurious and, indeed, beneficial to the health and living comfort of the elderly; 2. Institute a policy of demographic and medical research into the impact of curtailed energy use on health, comfort, and well-being of the elderly; and 3. Disseminate information to health professionals that will: a) make them aware of the effects of cold and heat and reduced energy consumption on the elderly; b) better enable them to recognize and treat health-related problems in the elderly that are attributable to extremes of temperature and energy limitations; and c) enable them to prescribe and disseminate information that will help prevent hypo- and hyperthermia-related illnesses and injuries to the elderly population.

Housing

Higher energy costs often create special housing problems for elderly persons because of the specific qualiities of the dwellings many of them occupy. A research study of housing for the elderly said that more than 50 percent of all older persons live in major metropolitan areas, about 40 percent in small towns, and only five percent on farms.[7] Elderly persons, more often than others, live in housing with heating problems.

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[7] The Housing Situation of Elderly Americans, The Urban Institute, Washington, D.C., November, 1976.

"Elderly-owned homes usually have a lower dollar value than other owner-occupied homes do. This suggests that the elderly are living in homes that are less well constructed and less adequately insulated than the norm. There are indications that elderly persons also spend less for home improvements and maintenance than the general population. This would also support the conclusion that their homes are less likely to be adequately insulated."[8]

Weatherization efforts can help to increase conservation among older persons desiring to stay in their own homes. Several Federal programs provide direct assistance for weatherization. However, weatherization is not cost-effective for many old and dilapidated buildings which require extensive and costly rehabilitation rather than simple energy-saving changes.

Energy costs in homes for the aged have skyrocketed in recent years, and these costs have increased the prices older persons and their families must pay for this kind of housing, said a spokesman for the American Association of Homes for the Aged.

Resolution Topic: Housing

Description of Problem: Insufficient Weatherization

Many older people must endure special hardships in order to conserve energy. As compared to younger people, they are less able to survive extremes of temperature, more likely to suffer from chronic and acute illnesses, and less able to weatherize their own homes.

Statement of Recommendation: Therefore be it resolved that:

1. Congress should authoritze more Federal funds for residential programs.

2. The Federal government should expand present weatherization activities by developing labor through the Armed Forces, ACTION, Green Thumb, Senior Community Service Employment Program, Retired Senior Volunteer Program, etc. in addition to CETA.

3. Weatherization activities should be improved by expanding training programs and strengthening product and installation standards.

4. Alternative energy technologies should be utilized in new construction and the retrofitting of existing facilities.

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[8] Hearing before the Subcommittee on Housing and Consumer Interests, U.S. House Select Committee on Aging, September 26, 1978.

5. A variety of methods should be developed to finance weatherization and rehabilitation efforts. They should include tax credits, Federally-granted or Federally-insured market-interest rate loans, below-market interest rate loans, and loan deferrals (e.g. delay of payment until the property is sold or the estate probated). Taxing agencies should grant accelerated depreciation for the cost of the improvements.

6. The Federal government should relax income eligibility requirements for the rehabilitation and weatherization programs that it finances.

Description of Problem: Lack of Incentives for Independent Living

There are few incentives for friends, family, and the community as a whole to support independent living situations.

Statement of Recommendation: Therefore be it resolved that:

1. The Federal government should encourage family living arrangements. For example, SSI payments should remain unchanged for people electing to live with relatives.

2. Methods of reducing disincentives for new uses of elderly-occupied single-family units should be investigated.

3. Methods of increasing the energy efficiency of older housing units should be studied, with emphasis on local zoning and building codes, financing, and cost effectiveness.

4. Local authorities should relax restrictions that discourage shared housing.

5. New kinds of housing, such as congregate and small cluster, should be built to provide feasible alternatives to single-family homeownership.

6. Programs should encourage the development of smaller, more energy-efficient housing units, and older persons should be encouraged to move into this kind of housing through a variety of relocation incentives.

Description of Problem: Insufficient Housing Monies Available

Many elderly persons live in substandard housing which needs extraordinary weatherization and other, often costly improvements to increase energy efficiency.

Statement of Recommendation: Therefore be it resolved that:

1. The Conservation Bank should make conservation grants rather than loans, targeting those elderly with less than 80% of median income.

2. The Solar Bank should make the elderly a priority beneficiary for solar loans.

3. Cities and nonprofit Community Development Corporations should become lenders under the Solar and Conservation Bank and establish more lenient homeowning requirements for the elderly.

4. Cities should match Solar and Conservation Bank funds with local Community Development Block Grant (CDBG) funds.

Description of Problem: Need for Landlords to Receive Weatherization/Rehabilitation Incentives

The nation faces a severe and growing shortage of affordable rental housing. Few incentives exist for rental housing owners to institute weatherization and conservation measures.

Statement of Recommendation: Therefore be it resolved that:

1. A comprehensive program of weatherization and rehabilitation assistance should be developed for existing rental housing, with emphasis on housing for low- and moderate-income people. Priority should go to buildings occupied by a high proportion of the elderly. This program would: a) develop guidelines for determining the economic feasibility of retrofitting individual older multi-family structures; and b) require an agreement by the owner to keep rents at the pre-improvement level during some specified period of time. If the property changes owners, this agreement should remain in force.

2. Rent subsidy and home improvement programs should include special provisions to help elderly tenants improve a rental property's energy efficiency. A proportion of rent subsidies might be held in escrow or property improvement loans might be made available.

3. The Federal government should promote model local codes that require landlords and rental property owners to meet minimum energy-efficiency standards in order to continue to rent property or to declare property depreciation as income tax deductions.

4. Landlords should be allowed to keep part of the profits earned if they solarize their property.

5. HUD and FMHA should receive discretionary funds that would allow the development of projects that establish effective and flexible approaches for delivery of weatherization and conservation programs.

6. The current policy of encouraging conversion to individual meters from master meters in multi-family rental housing should be abolished because of the tenant hardships and inefficiency created by the conversions. HUD regulations and Federal tax credits and loans should not subsidize these conversions. State regulatory agencies should adopt new regulations that prohibit conversions from master-meter situations to individually-metered situations.

Minority Opinion:

Individual metering in multi-family dwellings historically has encouraged conservation, which is consistent with the nation's interests. This is a more equitable approach because consumers only pay for what they use. Help should go to those persons who need help to pay their bills.

Meaningful Roles (Employment and Volunteer Opportunities)

Despite the severe hardships that rising energy prices have imposed on elderly people, many older persons across the nation have demonstrated that they are not content to play a passive role during the energy crisis. Many are working as paid employees or volunteers to help solve the problem. Older persons often can work more effectively than younger people to give energy assistance to other elderly. They have direct experience with the special energy needs of their peers and with the programs that are tailored to meet these needs.

Older persons have demonstrated a willingness to dedicate time to energy assistance programs and success in helping make the programs work.

Resolution Topic: Meaningful Roles

Description of Problem: Limited Energy-Field Employment
Opportunities for Senior Citizens

Several practices prevent the elderly from finding employment in the energy field.

Statement of Recommendation: Therefore be it resolved that:

1. Energy employment opportunities for seniors must be expanded with emphasis on flexible work patterns, flexible work weeks, and adjusted salary schedules. Further, existing age discrimination laws should be rigorously enforced.

2. Federal regulatory barriers to participation in the workforce by seniors should be identified and removed (for example, reduction in Social Security benefits for dollars earned). Mandatory retirement should be eliminated.

3. Intergenerational interaction should be encouraged by involving both younger and older Americans in energy-related training programs.

4. Employment of elderly in Federally-supported energy programs such as the Solar Bank, weatherization programs, residential conservation services, etc. should be encouraged. Business, industry, and community leaders, as well as service providers, should be educated about the roles that older persons can play in energy programs.

5. Local chambers of commerce, voluntary action centers, and other appropriate organizations should develop energy skills banks to include those who have skills which could be utilized in solving energy problems and those who would be willing to be retrained to work in energy projects.

6. Congress should provide increased tax incentives to encourage the private sector to employ the elderly in energy-related projects.

7. Necessary training that will enable seniors to enter energy-related fields should be developed and offered nationally.

Description of Problem: Inadequate Information Distribution

There is inadequate information distribution concerning education, employment, and training for elderly persons in energy-related occupations.

Statement of Recommendation: Therefore be it resolved that:

1. The Social Security Administration should publicize energy education, training, and employment programs.

2. Information and referral center personnel, outreach workers, and other agency staff serving the elderly should be trained concerning energy education, employment, and training opportunities.

3. Senior centers and other older Americans' programs and organizations should be used to disseminate information about energy-related opportunities for voluntary and employment roles.

Description of Problem: Disincentives to Volunteerism

The increase in fuel costs, decrease in available fuel, high cost of auto repairs and maintenance, and expense of insurance have resulted in disincentives to volunteerism. This results in increased costs for services, cutbacks in the sporadic availability of services, and reduction of the amount of informal sharing.

Statement of Recommendation: Therefore be it resolved that:

1. Tax systems at the Federal, state, and local level should be utilized to create incentives to volunteerism.

2. Public and private agencies should be encouraged to reimburse volunteers for out-of-pocket expenses. To encourage this effort, the agencies might obtain tax incentives. Funds to reimburse these expenses should be made available through government and private sources.

3. Low-cost liability insurance should be made available to agencies using volunteers.

4. Funds available under the Windfall Profits Tax should be used to supplement public and private volunteer programs operated by senior citizens' organizations, private voluntary groups, and local government initiatives.

Description of Problem: Need for Advocacy

The elderly represent a potentially powerful collective force in the resolution of energy problems, but the potential has not been fully realized.

Statement of Recommendation: Therefore be it resolved that:

1. The existing aging organizations should advocate for the resolution of the elderly's energy problems.

2. Older persons who possess appropriate knowledge and useful expertise should be utilized as resources to advocate, establish, deliver, and evaluate energy services designed for older persons.

3. Aging organizations should commit resources to organizing older persons in order to enable them to participate in these activities.

4. Aging organizations should be urged to organize coalitions of service providers (energy and social services) and other appropriate organizations to advocate for and facilitate the coordination of aging-related energy programs.

Follow-up

Additional information about the Energy Equity and the Elderly Mini-Conference is available by contacting: Program Development Section, NRTA-AARP Program Department, 1909 K Street, N.W., Washington, D.C. 20049.

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Mini-Conferences have been recognized by the 1981 White House Conference on Aging and convened by organizations that wished to focus attention on special aging issues.

Recommendations of mini-conferences are not the recommendations of the official delegates to the Conference or the U.S. Department of Health and Human Services. They represent the views of the participants in the mini-conferences. They are being made available to the delegates as part of their background materials for the national conference.

The following Mini-Conference Reports have been published:

Recreation, Leisure and Physical Fitness
Aging and Alcoholism
Energy Equity and the Elderly
Public/Voluntary Collaboration: A Partnership in contributing to independent living for the aging
National Health Security
Concerns of Low-Income Elderly
Vision and Aging
Alzheimer's Disease
Arts, the Humanities and the Older Americans
Older Women
Life-Long Learning for Self-Sufficiency
The Urban Elderly
Rural Aging
Long-Term Care
Non/Services Approaches to Problems of the Aged
Spiritual and Ethical Value System Concerns
Transportation for the Aging
American Indian/Alaskan Native Elderly
Pacific/Asian Elderly "Pacific/Asians: The Widsom of Age"
Environment and Older Americans
Rights of the Institutionalized Elderly and the Role of the Volunteer
Veterans
Mental Health of Older Americans
Saving for Retirement
Hispanic Aging
Challenging Age Stereotypes in the Media
Oral Health Care Needs of the Elderly
Housing for the Elderly
Consumer Problems of Older Americans
Senior Centers
Elderly Hearing Impaired People
Black Aged
Legal Services for the Elderly
Simplifying Administrative Procedures and Regulations in Programs Affecting the Elderly
Intergenerational Cooperation and Exchange
Self-Help and Senior Advocacy
Euro-American Elderly
Inter-relationship of Government, Private Foundations, Corporate Grant-Makers and Unions
"The National Dialogue for the Business Sector"
Foot Health and Aging
Pacific Islanders Jurisdiction
Gerontological Nursing

the 1981
White House
Conference
on
Aging

Report of the Mini-Conference on Non-service Approaches to Problems of the Aged

MCR-2

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

REDISCOVERING GOVERNANCE

Nonservice Approaches to Problems of the Aged

A White House Mini-Conference

February 6, 1981

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Sanctioned by the 1981 White
House Conference on Aging
Supported by the Administration
on Aging and SRI International

Findings and Recommendations

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Nonservice Approaches

Introduction

On February 6, 1981, a White House Mini-Conference was convened by SRI International under the auspices of the 1981 White House Conference on Aging and with the support of the Administration on Aging.

The Mini-Conference brought together 70 participants from state and local government, state and local units on aging, community-based advocacy organizations, the private sector, the nonprofit voluntary sector, and the mutual support sectors. The agenda of the meeting was to consider how local governments can mobilize their own resources, and those of the private and mutual-support sectors through the use of traditional governance tools in new ways and through establishing new relationships that better respond to the needs of the aged. The meeting focused on what have been called nonservice approaches to problems of the aged.

The meeting invited participants from different sectors to state their views on how nonservice approaches to problems of the aged could be used and specifically what steps need to be taken to increase their use. The basic question considered by the Mini-Conference was the extent to which increasing the capacity of both governmental and nongovernmental sectors to develop nonservice approaches should be a fundamental element of the 1981 White House Conference. These proceedings present the theme of the conference and the key findings and recommendations made by participants.

Nonservice Approaches: Using the Ability to Govern as Well as the Ability to Spend

The problems of the aged, in many cases, result from characteristics of markets (housing, employment), actions of public and private institutions (individual firms, landlords, hospitals), and behavior of individuals (family, friends, and neighbors), as are the problems of other populations. The traditional human service delivery system is designed to fill gaps and, to some extent, ameliorate flaws in these systems. However, growing fiscal constraints, changes in needs, and fundamental attributes of service delivery systems have necessitated development of additional ways of responding to problems of the aged.

Public, private, and mutual-support sectors each play an important role in meeting the needs of the aged. While each sector can change its own practices and policies to better respond to issues in aging, there are many actions that local government can specifically take to assist other actors or to provide inducements to better response. The use of nonservice approaches represents a way in which local government can initiate or be encouraged to provide appropriate incentives for better mobilization of each sector's resources.

Nonservice approaches are based on the use of traditional governance powers by local government in new ways. Governance powers, such as regulation and deregulation, tax policy change, administrative reform, promotion of self-help, and public advocacy can be used to influence the behavior of markets, institutions, and individuals. Local governments can also encourage and assist in the creation of new roles and relationships between the governmental and nongovernmental sectors and within the private sector.

Used in these ways, nonservice approaches can provide the low-income elderly with alternatives to markets they can no longer participate in effectively, such as housing, or transportation. Nonservice approaches can address the actions of institutions to help them become more responsive to needs of older adults in such areas as employment opportunity, and for continued independent living. Finally, these approaches can address individual behavior by facilitating and providing incentives (or removing disincentives) for existing self-help activities (home care, activities of daily life) and new support roles (mental health, employment).

The purposeful use of nonservice approaches at the local level increases the range of tools government can use to address the problems and needs of the aged in specific local settings. While such approaches do not replace traditional service delivery programs, they can reduce pressures on them by providing alternatives.

Constraints on Traditional Approaches

A complex shift in the social welfare needs of the aged and in the availability of resources for responding to those needs is taking place. The aged are growing in number and could easily reach 30 million by the year 2000. Independent living, deinstitutionalization, and continuation of existing life-style are key issues and objectives among the aged. Current policies of service delivery attempt to respond to these objectives. Yet, despite the $150 billion spent in 1979, direct services cannot meet all of the needs that exist.

In addition, the current fiscal climate is such that growth in both categorical and local program funds is likely to be constrained. Tax limitation initiatives have seriously impaired the ability of local governments to carry out service delivery activities. The ability to use expenditure-based service delivery strategies has slowed down, and local governments have started to recognize that these approaches could not, even given unbridled growth, ever meet all needs. Certain service delivery activities are perceived as inappropriate for clients, compounding concern over use of scarce resources. All of these conditions have encouraged local governments to examine what they could use in addition to, or rather than direct expenditure to complement and expand existing services.

Categories of Nonservice Approaches

The six basic types of nonservice approaches that can be used to better utilize public and nongovernmental resources are described below.

Regulation and Deregulation--The police powers provided to local governments by the states represent tools with which cities and counties have traditionally pursued maintenance of the health, safety, and welfare of their constituencies. Regulatory mechanisms have traditionally been used to prevent action construed by local government as being against the public's best interest, such as zoning to prevent incompatible land-use or licensing to prevent unsafe practices.

Nonservice approaches to regulation are based on using traditional local powers in ways that emphasize positive action. Nonservice approaches using regulatory powers can also involve purposeful deregulation, designed to encourage desired behavior by nongovernmental actors. Thus, through the intentional targeting of regulatory powers, local governments can promote and marginally direct certain market-focused activities, such as protecting low-income housing stock, stimulating provision of care, preventing discrimination by institutions in housing and employment, and enabling mutual assistance activities (homesharing and paraprofessional roles).

Specific approaches include:

- Flexible zoning and code enforcement to permit shared living arrangements such as shared housing and in-law apartments.
- Condominium conversion controls to protect housing units lived in by the elderly.
- Anti-age-discrimination ordinances to protect housing rights.
- Reduction of constraining licensing laws to allow food banks and health care alternatives.

Tax Policy Change--The traditional purpose of most forms of taxation has been raising money to fund specific programs of services. Cities and counties, however, have recognized some nonrevenue implications of tax policy and sought to use such implications to their advantage.

Nonservice tax policies such as flexible collection practices and deferrals can be used to reduce financial burden. Deductions can be permitted to encourage new social roles by families and businesses. Tax disincentives can also be used to protect vulnerable neighborhoods.

Specific approaches include:

- Locally administered property tax deferrals until sale of home which allow the elderly to keep their homes.
- Circuit breaker tax policies which reduce tax burdens.
- Tax exempt revenue bonds used to provide lower interest loans for housing for the aged.

Administrative Change--In the past, administrative procedures have been used in narrowly defined ways, often creating more obstacles to assisting special groups than opportunities. Local governments are now using administrative changes to address social and community objectives, such as improvement of housing stock and meeting social welfare needs. This is being achieved through the flexible use of public resources (such as schools, government buildings, buses), the targeting of administrative practices (such as code and tax delinquency enforcement), and development of innovative changes in administration to permit new roles for needy groups in public service (modified job classifications), and changes in the location and form of services.

Specific nonservice approaches include:

- Matching older adults for home sharing.
- Local government use of flextime and job sharing to make public sector jobs accessible to the elderly.
- Promoting organization of area-wide food salvaging, banking and distribution systems.
- Flexible use of public facilities for nonprofit service programs.

Public Advocacy--Local governments have become increasingly aware of how they and their constituents are influenced by local and intergovernmental policies. Consequently, cities and counties have become more aggressive in the use of their legal powers to deal with other levels of government and the private sector. Jurisdictions have sought redress of resource allocation inequities in court against adjacent communities, public bodies, and private sector actors. The reduction of rate increases by utilities or insurance companies are issues around which law suits have been brought. Cities and counties are also using their inherent corporate power to lobby politically on critical issues at state and local levels.

Specific examples include:

- Advocacy before state legislatures to enable private sector use of reverse annuity mortgages.
- Advocacy of state elimination of retirement age in public and private sectors.
- Rate reduction lawsuits against discriminatory lending and auto insurance policies .
- Advocacy for tax reforms to shift burdens from the poor and to encourage private giving.
- Advocacy for expansion of PSRO's to cover office visits, clinic visits.

Public-Private Collaboration--The nonservice concept views the private sector as an integral element of the community, with responsibilities and potential for meeting needs of the community, as well as needs of its owners, clients, and employees either directly or as a partner with local government. The private sector can use powers such as direct giving, in-kind assistance (professional advice, loaned manpower, facilities, training), operations (direct services to employees and the community, design of products), and use of investment power to aid the elderly. Local government can promote use of such private sector resources and develop joint approaches to some problems.

Specific nonservice approaches include:

- Investment by private firms and unions in housing for the aged, and housing rehabilitation, with local government providing incentives to promote this action (flexible zoning, tax incentives).
- Increased work opportunities for retired workers (organization of private employment firms for aged, flexible scheduling).
- Nursing students and interns providing screening in public housing, and congregate care units, with local government facilitating organization of services in public facilities.

- Business programs to encourage well-being of older employees, and develop health resource access for older community residents.

Promotion of Self-Help--Although America has a tradition of placing emphasis on the role of self-help and voluntary associations in meeting community needs, local governments have generally done little to facilitate this process. Increasingly, however, public decisionmakers are recognizing the significance of individual neighborhood-level, and community organization approaches to directly meeting community development and social welfare needs. Self-help (including mutual help and informal support) can be of particular importance to the aged because it supports traditional values of avoiding dependency and stigmatization.

Specific nonservice approaches include:

- Group living cooperatives and housing brokerage, with government support of these alternative arrangements.
- Older adults organizing private nonprofit employment firms that provide new jobs for seniors.
- Organization of food buying clubs, food banking, and distribution centers, with local government waiving constraining regulations, offering space and equipment.
- Organization of peer-assistance activities, such as widow to widow counseling, with local government reducing regulations and administrative constraints on paraprofessionals, and incorporating such activities in senior centers and welfare offices.
- Mutual support activities for elderly (home visiting), with local government SSI Title XX providers identifying family, neighbor, or community supports.

Constraints on the Use of Nonservice Approaches to Address Needs of the Aged

The six categories of nonservice tools can be used in a number of different ways to address local problems. To date, however, few local governments have systematically examined how they could use nonservice tools to strengthen public and nongovernmental sector response to specific problems, particularly those of the aged. Studies have found that most local governments are using one or more approaches in a reactive way to problems they perceive, such as downzoning a neighborhood to stop displacement of residents. Little attention has been given to considering the context of problems and how the broad array of local actors, both governmental and nongovernmental, could be brought to act on a given problem. Often there is a strong line agency, or program point of view that narrowly defines the potential target or beneficiary of a policy change. This tends to preclude other agencies (e.g., the tax assessor, fire department, purchasing, or planning department) from considering how the policy tools they can direct could be applied to an issue of another target group, such as the aged. Thus, the policies of the planning commission concerning housing are rarely examined by the social welfare department or area agency on aging in terms of how they might affect the housing supply for the aged.

How Different Sectors View Nonservice Approaches

William J. Hanna, Director, Division of Services for the Aging, Colorado set the overall theme for the White House Mini-Conference when he said:

"Unfortunately, the mere existence of the White House Conference on Aging tends to drive participant's thoughts--mine included--into a federal-government-targeted mentality. After all, this is a national conference and therefore directed toward national (i.e., federal government) policies. This mindset is difficult to overcome, and sets the participants into a 'them' and 'us' dichotomy. We are going to Washington--either in person, or through our written recommendations--to tell them (generally the government) what they should do to make it better for us. My purpose is to suggest a redirection of this bias. For the White House Conference on Aging can also provide an excellent forum for us to speak to ourselves about what we can do locally to make it better for all of us."

Local General Purpose Government

City and county governments across the country are making use of nonservice approaches to address the needs of the aged, as Mayor William E. Hanna, Jr. of Rockville, Maryland said:

"Essentially, then, Mayors and other local officials must address the question of resource allocation. We have a choice of cutting services to the 'truly needy' or seeking more effective and efficient uses of available resources. [One way is] a nonservice strategy as an alternative approach to ensure the necessary services for the elderly. Rather than the local governments providing or funding direct services to the elderly, this approach seeks to utilize the governance powers of local governments to facilitate services."

Many innovative strategies being used by local governments were described in the meeting. For example, nonservice approaches are being used to address individual aspects of the need for affordable housing. In many places homeowners are being allowed to request zoning waivers to allow the construction of "granny flats" for elderly parents. Condominium control ordinances are being enacted in some cities; homesharing programs are being started in others. No city or county, however, appears to be examining the local scene to identify all of the opportunities to use nonservice approaches that would increase the supply of appropriate and affordable housing available to the elderly.

To expand the use of the nonservice approach to problems, it will be necessary to provide incentives to local governments to adopt nonservice approaches. Local governments are now rewarded for new service delivery programs by larger budgets, more staff, and higher counts of numbers of persons served. Nonservice approaches to problems, although they may provide more lasting and satisfactory results, have no such rewards. In addition, because they address causes and because they entail change, nonservice approaches may take greater initial innovative capacity among staff than service delivery approaches in which compliance and productivity are the main emphases at the local level.

More understanding of how nonservice approaches relate to service approaches is also needed. As Doris Dealaman from Somerset County said:

"We need to develop some understanding of how nonservice approaches relate to service approaches...how serious a problem can we address with a nonservice approach? In particular, can we identify those areas and programs which cannot be replaced by nonservice approaches, no matter how politically and financially attractive such cut-backs might appear?"

Nonservice approaches also result, some participants pointed out, in the private sector and individuals taking responsibility for some services that will, as a result, no longer be under the control of local officials. Elderly persons, for example, may prefer self-help housing arrangements that do not meet the standards of appropriateness that govern some publicly financed housing. Also, some measures adopted by local community groups or churches may benefit specific groups of elderly who live in one neighborhood or belong to a particular church. Thus, the pluralism inherent in nonservice approaches by the private sector may require the development of new attitudes and techniques among local governments in areas where the government itself is not employing nonservice approaches.

Local governments can be constrained in the kinds of nonservice approaches they can consider by intergovernmental factors and by the particular configurations of capacity and policy in the local private sector (including both business and the nonprofit or voluntary sector). For example, tax policy is not set at the local level in many states.

There are also political constraints within jurisdictions. For example, local use of tax policy change may be permitted by state law, but limited by local fiscal needs that make it politically risky to seek approval for any tax measure that would either increase tha tax burden or decrease local revenues. Changes in zoning may be opposed by homeowners who fear some loss of market value as a result of permitting homesharing in single-family residential areas or the installation of mobile homes as "granny flats."

Finally, because the opportunities for the use of nonservice approaches are often specific to local jurisdictions with their political, intergovernmental, and private sector constraints, particular nonservice approaches can rarely simply be mandated by a higher level of government. At the same time, higher levels of government can encourage the adoption of nonservice approaches by rewarding their use, by assisting local governments to develop their own capacity to implement nonservice strategies, and by encouraging the private sector to implement nonservice strategies.

In sum, local governments have an inherent capacity to use governance tools to more strategically address problems of the aged by refocusing their own roles and encouraging nongovernmental sectors. However, cities and counties have to increase their knowledge of alternative approaches and overcome the particular local and intergovernmental obstacles they face.

Area Agencies on Aging

Area Agencies on Aging (AAAs) have been quite active in developing nonservice approaches to address the problems of the aged, particularly nonservice strategies using volunteers. As Commissioner Adelaide Attard of the Nassau County Department of Senior Citizen Affairs in New York said: "We see an ever-increasing involvement of the private sector with [AAAs] to help underwrite the cost of providing services to the ever-growing senior population."

At the same time, AAAs established at one level of government (the county, for example) may tend to be isolated from local government at other levels (the city, for example), and may tend to form relationships with only that portion of the private sector that is specifically concerned with aging. Such isolation can limit the kinds of nonservice approaches AAAs can consider; for example, without close interaction with local government, the AAA can only react to, not help to initiate, nonservice strategies that depend on the use of local government powers. Similarly, without that close interaction, nonservice strategies that the AAA desires may be blocked by local government. In Nassau County, for example, homesharing agreements had been reached with landlords, but the actual possibility of homesharing did not exist in many areas because of zoning regulations. Thus, there is a strong opportunity for AAAs to increase their effectiveness in helping to develop nonservice approaches by linking with all levels of local government, including the elected officials, rather than working with functional departments or only with the level of government at which they are established.

State Government

Many states are now explicitly examining the potential of nonservice approaches. For instance, Cynthia Koeck, representing the Human Resources Division of Minnesota's State Planning Agency, said:

"It has been quite clear in our examination of the programs and policies affecting the elderly that many programs are characterized by a presumption of need by all elderly individuals and a presumption that providing services to those individuals is the best way to meet that need. It is our feeling, based on the preliminary results of our study, that (1) all elderly may not have service needs, and (2) the traditional programs and services may not be the best way to meet the needs that do exist."

The role of state government in implementing the development of nonservice approaches is different in significant ways from the role of local generalpurpose government. States can provide incentives for local governments to consider nonservice approaches, can fill an important networking function, and can enable (by legislation or changes in regulations) the development of new types of local initiatives. For example, a state legislature can permit the use of reverse annuity mortgages so that elderly persons who own homes that have appreciated to a very high market value can convert that asset into an annuity without losing the home. Similarly, a state insurance commission can require that volunteer drivers be insured at a rate that is not as high as the commercial drivers rate to encourage volunteer drivers.

One major concern of state government about nonservice approaches is that they may not have the intended effect on the intended target population. Another concern is that they not be used either at the local level, or at the federal level as replacements for the delivery of needed services.

State Units on Aging

State units on aging are in an excellent position to act as advocates for nonservice approaches. In particular, they can make sure that state agencies take account of the needs of the elderly in regulations and practices even though the agency focus may be quite different. For example, Mrs. Lou Glasse, Director of the New York State Office for Aging, reported that in New York State, the unit on aging at the state level was able to make sure that programs in crime prevention and housing rehabilitation took account of the needs of the aged in localities in which they were set up.

At the same time, state units on aging are in an excellent position to carry out a networking function among local governments to make sure that information on nonservice approaches used successfully in one jurisdiction is available to others that might adapt such approaches for their own needs.

Some state units on aging can address problems that local programs designed to meet the immediate needs of the aged cannot meet. As pointed out by William J. Hanna, programs that assist the elderly by giving them funds to pay their heating bills are, in effect, subsidies to fuel companies. A state weatherization program grant can alter that relationship, but may involve liens that are unacceptable to elderly homeowners. In this context, state units on aging may be in a particularly valuable position to explore new patterns of response that take account of both the needs of the aged and the needs of business.

Community Based Advocates

Organizations such as the Gray Panthers, the American Association of Retired Persons, and neighborhood associations of various kinds can not only mount nonservice approaches of their own but advocate nonservice approaches at the local and state levels.

William J. Hanna pointed out, however, that "'ownership' of issues facing seniors cannot be limited to the elderly and their advocates, or to one level of government or sector of society. Effective advocacy often requires that community groups organized among the aging support initiatives that will for example, help all low-income people, not only the low-income elderly, those that will help all disabled people and not only the disabled elderly, and those that will help all families, not only those with elderly family members. Examples might include advocacy for local condominium conversion control ordinances or for state Good Samaritan laws that release the donor of goods from liability for defects in those goods.

According to Joseph Davis, who chairs the Housing Task Force of the National Gray Panthers, both the old and the young in many cities have a strong mutual interest in affordable housing and have been working vigorously together to develop programs whereby tenant associations can buy apartment houses scheduled for condominium conversion and convert them to co-op housing.

Finally, Sidney Gardner of the Hartford City council (Hartford, Connecticut,) added:

"Lobbying which is predictable is discounted heavily in the political arena. Every legislator expects to see agency executives and boards defending their own programs, and when public sector cuts affect the voluntary sector, such lobbying is widespread. What is less predictable--and thus more effective--is broad-based advocacy on behalf of clients, other programs than one's own, and allocations to a broad functional area rather than solely to one's own program. Whether advocacy will be so defined by voluntary groups serving the elderly may do much to determine the effectiveness of such advocacy in years to come."

The Business Sector

The private sector already represents an important source of supports for the aged. However firms can extend the resources available to address the problems of the aged by contributing funds, by lending expertise, facilities, or equipment, by investment, or by targeted use of ordinary business operations. Firms can collaborate among themselves, with government, with voluntary organizations or they can act independently. In several cities, firms give discounts to seniors. In one city, a church provides facilities for a senior center and the carpeting for the center comes from a corporate headquarters that renews its foyer carpeting annually. Corporate contributions maintain the Baltimore Fuel Fund, which helps offset energy costs for low-income groups. One company has an executive--on full pay--loaned to an Area Agency of Aging to develop a preretirement counseling program for local companies. Corporations also are looking at the development of respite care facilities for elderly relatives living with employees, are hiring retired employees as vacation replacements, are investing in housing for the elderly, and so on.

Private firms, whether large or small, have valid interests that are served by aiding the elderly. For some, it is a matter of maintaining a corporate history of being interested in the larger community; for others, it may be a matter of improving conditions for the company by improving the community as a whole; for still others, aiding the elderly is their line of business. Also, companies may address specific income and social integration needs of the aged by making an effort to change their policies towards older workers. This is increasingly involving such policies as flexible work scheduling, job sharing, and definition of new work roles.

Local governments as well as members of the private sector, are increasingly giving thought to how changes in public sector policies can strengthen private policies beyond their current level. Government and firms are examining how local government tools, such as zoning, code practices, tax incentives, and administrative changes can be collaboratively developed to enable meeting needs of the aged. It is here, in a more organized manner, that nongovernmental resources, such as housing, employment, and social supports, can be more effectively mobilized.

The Nonprofit Voluntary Sector

The nonprofit voluntary sector has long been involved in meeting the needs of the aged. However, as Sid Gardner, a member of Hartford's City Council said: "The context of this involvement is changing. Financial strains such as inflation, are eroding the impact of charitable dollars. The proportional private funding of nonprofit agencies is outweighed by current public dollars. Increased regulation of voluntary agencies, through purchase of service contracts and pressures for accountability in the use of public funds by nonpublic agencies are constraining innovative use of resources for the aged. There is also increased competitiveness between nonprofit organizations for scarce charitable resources and public contracts."

Under all these pressures and trends, interest in nonservice approaches has grown among nonprofit and voluntary organizations. Although these activities have often been informal and unsystematic, there are five areas where nonprofits are increasingly pursuing nonservice policies.

First, nonprofit voluntary agencies can advocate for tax policy change. At local, state and federal levels, tax policies that encourage charitable giving by the private sector and individuals are a particular area of interest among nonprofits. Advocacy for reform of tax policies that directly impact the aged is another form of tax policy change that is being undertaken.

Second, advocacy is being targeted on specific service delivery and legal issues confronting the aged. Nonprofit organizations are participating in planning forums as well as litigation that helps to better ensure existing resources are provided to those most in need. Issues being addressed include location of senior centers, the routing of public transit, and patterns of community development.

Regulatory policy is a third area of advocacy that nonprofit organizations are undertaking. Nonprofit-voluntary agencies are affected as both the targets of regulation (licensing, certification and other operational constraints) and the potential beneficiaries of deregulation in certain areas. Nonprofit voluntary organizations are working examining how their operations are affected by regulations and how they can encourage reforms that enable them to better serve special populations, such as the aged in broader and more cost effective ways.

Fourth, nonprofit-voluntary organizations are using nonservice approaches involving collaboration with the private sector. They are finding that certain activities, such as establishing a senior center, or a wellness program can be enhanced by corporate or small business participation, both in terms of donations of materials and expertise. Such activities may range from the development of an adult day center within a firm to donation of carpeting and furniture to a senior center.

Finally, nonprofit-voluntary orgnizations are beginning to pay attention to their own role in strengthening mutual-support activities in the community. Some organizations are providing supportive service to children who are taking care of frail parents. Other organizations are helping to organize self-help networks in neighborhoods.

In sum, nonprofit voluntary organizations are using nonservice approaches to meet the needs to the aged as financial and administrative forces increasingly constrain their activities. Advocacy on tax, regulatory policy, adminstrative reform, collaboration with the private sector and promotion of self-help are emerging as essential roles for the nonprofit voluntary sector to play in order to assist the aged.

Self-Help Groups and Citizens

Although there have been extensive changes in family composition over time, as well as in a wide range of social mores and values, the practice of self-help, mutual aid, and informal support has endured. Self-help includes the kinds of informal support provided by relatives, neighbors, and friends, for frail or homebound elderly, the kind of mutual aid where a neighbor shops for an elderly widow in return for sewing and mending services as well as community gardens and food-buying clubs.

While family based self-help has always existed, self-help in the past was not always spontaneous but was fostered by a variety of institutions including churches, fraternal organizations, and voluntary associations of all kinds. Mrs. Phyllis Ehrlich from the Rehabilitation Institute of Southern Illinois University pointed out that training is needed to teach groups how to organize self-help and mutual aid programs and how to tap informal support networks.

Government sometimes set up barriers to self-help. For example, if several elderly people share a home and the tasks of maintaining that home and assisting each other, their income as a household is counted for the purpose of computing SSI or Food Stamp eligibiliy, this effectively excludes homesharing for low-income elderly, no matter how appropriate it would be for a particular group of elderly or how much less it would cost than housing each one individually and paying for the supporting services.

A second kind of barrier to self-help, which can be found in the voluntary agencies as well as in the public sector, is that many agencies are available to provide direct services but there is no routine system or group that is available to act not as a provider but as matchmaker, a broker, or a facilitator for self-help or informal support. If an agency worker provides a brokerage service, he/she may be out of compliance with agency guidelines if one of the persons helped is not eligible for agency service delivery. If a worker gets a neighbor to agree to drop in daily and make sure everything is all right, that usually does not count as an agency friendly visit in reports to a funder.

Local, state, and federal governments need to consider how to encourage and reward the range of self-help and mutual support activities that exist or could exist. While many studies demonstrate that mutual supports are both essential for well being and for meeting basic needs, local governments have only started to examine how their regulatory, tax and administrative powers could be used to promote actions in this sector. New approaches that are emerging include encouraging the role of nonprofit providers in helping the helpers (family) to help maintain their involvement. Local governments are also refining traditional professional roles and use of facilities to provide opportunities for self-help. Local governments now need to increase their use of policies that strengthen self-help in all these areas.

FINDINGS AND RECOMMENDATIONS: AN AGENDA FOR ACTION

State and Local Governments

State and local governments can play an important role in mobilizing their own resources and those of the private and mutual help sectors to address problems of the aged by using nonservice approaches. These approaches include the traditional governance tools of regulation and deregulation, tax policy change, administrative reform, and public advocacy as well as collaboration with the private sector and promotion of self-help. Although localities do show more use of nonservice approaches to help the aged than to help other needy populations, there is not yet any comprehensive or systematic application of nonservice approaches. The development of more systematic applications could be furthered by making more information available, reducing local and intergovernmental constraints, and providing federal and state incentives to using nonservice approaches. Specific suggestion are:

- More information exchange and networking is needed on the use of nonservice approaches to assist the elderly. Networking should extend beyond the official agencies on aging and providers. For example, public interest association newsletters can convey information about specific nonservice approaches in small as well as large cities. Community-based organizations can also participate in information exchanges and networking. Better inter-federal networking is also needed.

- Information exchanges concerning nonservice approaches should emphasize concrete benefits as well as identifying costs and cost-shifting effects. The risks of over-promotion and over-institutionalization need to be avoided by reporting failures as well as successes. While it is reasonable to tie the preventive rationale for nonservice approaches to community-wide self-interest in long-term saving, it must be made clear that nonservice approaches cannot be substituted for needed services.

- More generally the complementary nature of service delivery and nonservice approaches should be stressed; they are mutual, not competitive. At the same time, any new service delivery program should be accompanied by a systematic assessment of possible nonservice alternatives for those who may find the service inappropriate or inadequate.

- It has also been recognized that nonservice approaches are not cost-free. They often involve cost shifting (tax deductions) or changes in responsibility (devolving service responsibility to the nongovernmental sector). The nature and impact of these costs, in comparison to the benefits generated by nonservice approaches to problems of the aged, need to be better understood.

- Special purpose components of government, such as state or local units on aging can play an important role in development and advocacy of nonservice approaches. Increasing this capacity is essential if nonservice alternatives are to be promoted.

- Finally, local governments can not only bring governance powers to bear on the problems of market, institutional actions, and individual behavior, but they can also encourage the mobilization of private sector resources and capacities, whether in public-private collaboration or in the promotion of mutual help, and contribute to private sector initia- tives. Similarly, local, state, and federal policies can encourage or inhibit the adoption of nonservice approaches in the private sector.

The Private and Nonprofit Sectors

Business and the nonprofit voluntary portion of the private sector have found increasingly important nonservice roles to play, alone and in collaboration with each other and with local government. Local government can encourage and assist such efforts, whether directly or by removing barriers that may have grown up over time. Specific suggestions are:

- Local government needs to monitor policies on a continuing basis to make sure that responsibilities shifted to the private sector do not outweigh the ability to fulfill them and that costs shifted to the private sector do not fall upon the portion of the sector least able to pay.

- Local government can develop a useful matchmaking, brokerage, and facilitation capability to aid private sector collaboration and a public advocacy capability before other levels of government to aid in the removal of barriers they may have set up.

- Nonprofit-voluntary organizations can undertake advocacy for regulatory changes that enable broader action on their parts, tax policies that increase voluntary giving (in the face of decreased public spending), collaborative roles between the voluntary and private sectors to address new or changing problems and, finally, the nonprofit voluntary sector can use its resources to strengthen mutual-support, where public resources do not.

The Mutual Support Sector

Citizens have always helped themselves and each other whether as relatives, neighbors, or friends. However, in todays highly mobile society local government can assist in mobilizing new kinds of informal supports and in removing barriers that inhibit self-help. Specific suggestions are:

- Community based advocates require increasing political sophistication to analyze and advocate for policy changes that affect the aged, or groups with interests in common. More information on policy advocacy is needed by community organizations.

- Citizens of all ages can participate in coalitions to advance shared agendas--supporting those measures that would benefit the elderly. Such coalitions are not struggles against government but for governance changes that will affect causes of problems.

Action Steps for the White House Conference

- Encourage state and local governments to use their public interest networks to examine and increase understanding of nonservice approaches to problems of the aged in national forums and dissemination activities.

- Strengthen the information base of community based advocacy to enable better capacity to promote nonservice approaches across sectors (public and nongovernmental).

- Convene business leadership nationally and within communities under the auspices of business associations with the explicit purpose of exploring nonservice approaches that can be undertaken by business, both alone in and collaboration with the public sector and nonprofit organizations.

- Define a low expenditure level federal role in promoting nonservice approaches at the local level, including developing flexible program guidelines and incentives, capacity building steps, and convening functions.

Conduct further research on the utility and cost-shifting effects of nonservice approaches to needs of the aged through public interest associations and research institutions. Encourage sharing of policy research findings by state and local governments in their own efforts.

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Mini-Conferences have been recognized by the 1981 White House Conference on Aging and convened by organizations that wished to focus attention on special aging issues.

Recommendations of mini-conferences are not the recommendations of the official delegates to the Conference or the U.S. Department of Health and Human Services. They represent the views of the participants in the mini-conferences. They are being made available to the delegates as part of their background materials for the national conference.

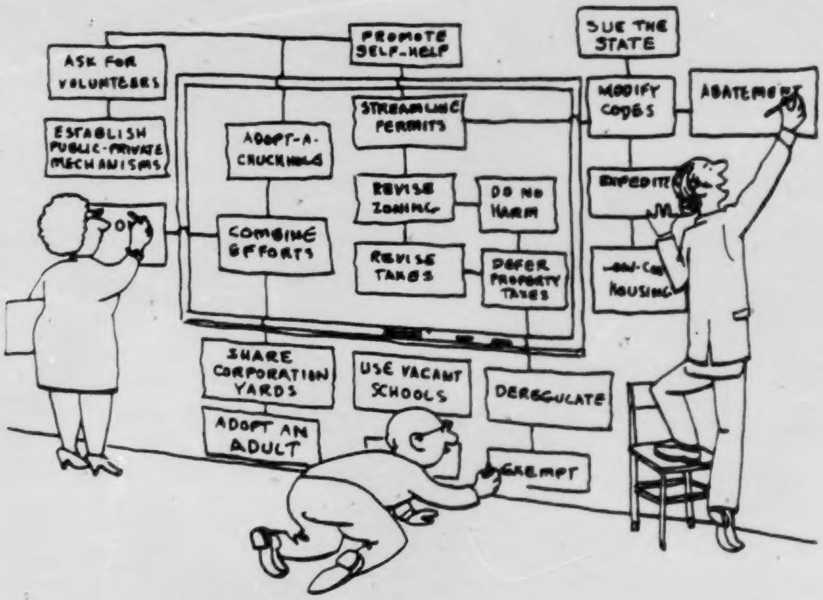
The following Mini-Conference Reports have been published:

Recreation, Leisure and Physical Fitness
Aging and Alcoholism
Energy Equity and the Elderly
Public/Voluntary Collaboration: A Partnership in contributing to independent living for the aging
National Health Security
Concerns of Low-Income Elderly
Vision and Aging
Alzheimer's Disease
Arts, the Humanities and the Older Americans
Older Women
Life-Long Learning for Self-Sufficiency
The Urban Elderly
Rural Aging
Long-Term Care
Non/Services Approaches to Problems of the Aged
Spiritual and Ethical Value System Concerns
Transportation for the Aging
American Indian/Alaskan Native Elderly
Pacific/Asian Elderly "Pacific/Asians: The Widsom of Age"
Environment and Older Americans
Rights of the Institutionalized Elderly and the Role of the Volunteer
Veterans
Mental Health of Older Americans
Saving for Retirement
Hispanic Aging
Challenging Age Stereotypes in the Media
Oral Health Care Needs of the Elderly
Housing for the Elderly
Consumer Problems of Older Americans
Senior Centers
Elderly Hearing Impaired People
Black Aged
Legal Services for the Elderly
Simplifying Administrative Procedures and Regulations in Programs Affecting the Elderly
Intergenerational Cooperation and Exchange
Self-Help and Senior Advocacy
Euro-American Elderly
Inter-relationship of Government, Private Foundations, Corporate Grant-Makers and Unions
"The National Dialogue for the Business Sector"
Foot Health and Aging
Pacific Islanders Jurisdiction
Gerontological Nursing

Nonservice Approaches to Problems of the Aged

A White House Mini-Conference

February 6, 1981


ASK FOR VOLUNTEERS
ESTABLISH PUBLIC-PRIVATE MECHANISMS
PROMOTE SELF-HELP
ADOPT-A-CHUCKHOLE
STREAMLINE PERMITS
REVISE ZONING
DO NO HARM
COMBINE EFFORTS
REVISE TAXES
DEFER PROPERTY TAXES
SUE THE STATE
MODIFY CODES
ABATEMENT
EXPEDITE
HOUSING
SHARE CORPORATION YARDS
USE VACANT SCHOOLS
DEREGULATE
ADOPT AN ADULT
EXEMPT

Findings and Recommendations

MCR-2

the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on
Long-Term Care

MCR-3

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

LONG TERM CARE

Policy Development and Implementation Division
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December 10-12,1980

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> "The strongest plea I want to make is that a person who receives requests from individuals who need long term care services needs to be the kind of person who is an advocate for that individual and who can be trusted as an advocate. It needs to be someone who is absolutely reliable and who you can tell the truth and get an answer without any fear that that information is going to be used for the benefit of any providers or anyone else. I don't know whether you know how demeaning an experience it is to have to go through all the time. Once you get the services, everything is marvelous and everything is taken care of. Advocates of long term care should know that people have to go through that demeaning experience every time they ask for anything that will help them carry on their lives in their own homes or elsewhere. It's a terrible thing to have to go through.
>
> If you can find someone in the core of your local community who will recognize what an outrage it is for a person who is in need of help, that would be the best thing you can do for your community."

A consumer of long term care services

Glossary of Terms

Long Term Care represents a range of services that address the health, social and personal care needs of individuals who, for one reason or another, have never developed or have lost some capacity for self care. Services may be continuous or intermittent, but it is generally presumed that they will be delivered for the "long term," that is, indefinitely to individuals who have a demonstrated need, usually measured by some index of functional incapacity. (Taken from Elizabeth Kutza's February 1980 paper on allocating long term care services)

Community Care Organization is a provider or coordinator of long term care services.

"Strengthening Community-Based Long-Term Care for Individuals"

EXECUTIVE SUMMARY

Introduction

Long term care has been identified repeatedly as one of the major areas of concern for the 1981 White House Conference on Aging. While the problems that exist in the current system of long term care have been enumerated and analyzed from many perspectives over the past several years, a consensus has yet to be reached among those in the field of long term care on a resolution of the problems at the federal, state and, particularly, at the community level. Needs assessment, cost factors, and utilization are but a few long term care issues which provoke far-reaching public debate. Recognizing these as major problems, the conveners of the mini-conference on long term care saw a need for policy direction and a need to stimulate action to strengthen community-based long term care specifically for individuals. An attempt was made to move away from a discussion of whether we should allocate substantial resources to long term care to a discussion of how we can develop a viable program to most effectively provide individuals with the care they need.

The mini-conference was a meaningful and successful experiment in bringing together, as a planning committee, a consortium of providers of services to the elderly to talk about issues that are of mutual concern. To best meet the challenges that long term care will inevitably undergo in the next several years, and to facilitate some of those changes, the long term care community has recognized that it must begin to conduct a serious dialogue and to work together on the basis of full cooperation. The timing of the mini-conference was critical, as it sparked the beginning of this cooperative approach. For this reason, the discussions within the conference were as important as the recommendations which emerged. Several significant assumptions provided the parameters for these discussions: the budgetary situation facing long term care will become even more severe and resources that have long been taken for granted will simply not be available; the role of the federal government in the provision of services will become less prevalent; the current system will continue to be inadequate to meet the needs of the increasing number of elderly individuals. These assumptions have several noteworthy implications for the future, about which there was a consensus among the participants at the conference: there is no one system which will be appropriate for every individual in need of services in each community; the emphasis on the community and on the informal support structures will increase sizably; and a partnership needs to be created between the government and the private sector on the financing and delivery of services. With this in mind, the conference work groups closely scrutinized how services are currently being delivered and how that method of delivery might be strengthened or broadened to more adequately relate to individual needs. It was an attempt to narrow a broad and even global perspective down to a delineation of options which might answer specific operational questions on long term care.

Organization of the Conference

The conference was organized by a steering committee comprised of representatives of the following eleven national organizations:

- American Association of Homes for the Aging
- American College of Nursing Home Administrators
- American Health Care Association
- American Hospital Association
- Council of Home Health Agency Community Health Services of the National League for Nursing
- Home Health Services and Staffing Association
- National Association of Area Agencies on Aging
- National Association of Home Health Agencies
- National Association of State Units on Aging
- National Council of Health Centers
- National HomeCaring Council

Over a period of three and one-half months, the committee met on a regular basis to report on assigned tasks and to make decisions about the planning, content and goals of the mini-conference. With the American Association of Homes for the Aging and the National HomeCaring Council assuming leadership roles, the consortium divided itself into five subcommittees, each with responsibility for planning one segment of the conference: logistics and finances; model projects; participants; resource gathering; and study questions. The conference itself was chaired by two persons who are highly respected in the field of long term care: Dr. Ellen Winston, president, National Council on the Aging, Inc. and Reverend Monsignor Charles J. Fahey, chairman, Federal Council on Aging.

Format of the Conference

The mini-conference on long term care was attended by 125 participants, among whom were government officials, Congressional staff, academics, providers, consumers and representatives of professional associations, payor groups, and national associations. The conference began with presentations from the directors of five model community long term care projects:

- Holyoke Geriatric Authority - Joseph Paul, Executive Director

- Washington State Model of Community-Based Care - George Telisman, Director, Southwest Washington Agency on Aging

- Monroe County Long Term Care Program, Inc. - Gerald M. Eggert, Executive Director

- The Association of Home Care Agencies, Cincinnati, Ohio - Carolyn Bruder, Executive Director

- Arkansas State Office on Aging - Service Management Project - Betty King, Director, Office of Aging and Adult Services

This was, in part, an effort to create a common framework for discussion and to develop an awareness of existing alternatives in community care service delivery. It also helped to reinforce the notions of choice and diversity in service delivery.

The bulk of the conference was divided into work sessions, with five separate working groups. Each work group was assigned one of five topics for discussion:

- Planning and Evaluation
- Program and Case Management
- Organization
- Human Resources
- Financing

Each work group was provided with a list of study questions prior to the conference, which were designed to probe various issues related to the topic, as a method for stimulating discussion. Each work group focused on three basic questions in reviewing their study questions and their issue areas: what are critical issues related to the topic and what impact might social, technological, economic and political trends have on the issues; what are the short-range policy implications; and, what are the long-range implications? "Group process" tools were used throughout work group sessions to help frame concise recommendations and to pinpoint areas of disagreement. In addition, the work of each group was reviewed by one other group to allow for structured analysis and feedback. The recommendations, as they were finalized by each group, are included in the text of this report.

Commonalities and Differences

It is worthy to note that within certain work groups there are proposed recommendations over which there was substantial disagreement. For example, the work group on human resources was unable to reach a consensus on three significant issues: whether to encourage support for the continuation of the three-year nursing school programs; whether proprietary organizations should be eligible as sponsors of and participants in federally-funded training programs; and whether the supply of human resources in the delivery of long term care services should be enhanced by providing tax credits to families providing long term care in the home.

However, there are also common threads of agreement among the recommendations from several of the work groups. Within all the discussions, attention was given to new opportunities in service delivery, to the independence of the individual and to individual concerns such as freedom of choice and quality of life. The role of the family and other informal supports, both in the delivery of services and in the financial aspects of a long term care system, was placed high on the list of critical issues among all the groups.

In addition, an informal consensus was reached on the need for comprehensive planning and coordinating mechanisms at the community level for the delivery and management of long term care services. This recommendation was reinforced by all five of the work groups, each with a slightly different focus, depending upon the assigned issue area.

It is important to point out that some of the traditional issues, such as institutional vs. noninstitutional, did not play a significant role in the deliberations. It is a noteworthy achievement that discussions concerning long term care have become more sophisticated and have moved to a level which calls for both ingenuity and broader vision.

Significance of the Mini-Conference

The mini-conference on long term care is an important contribution to the effort to provide policy direction and to encourage activity to strengthen community-based long term care to meet individual needs. It is worth noting that many of those who were involved in the discussions were practitioners in the field of long term care, most of whose day-to-day concerns varied greatly. However, the mini-conference encouraged the realization that the concerns of service providers are similar and the problems they face are all acute and often the same. It was imperative that a dialogue be encouraged among providers of services to the elderly. From this dialogue, which occurred throughout the conference, an awareness was developed of the continuum in long term care delivery at the community level.

The mini-conference is also significant in its development of policy guidelines for elements of long term care systems. The policy guidelines may need refinement and further study. However, they are a thoughtful and substantive basis on which to build policy.

Finally, the mini-conference on long term care was successful in fostering cooperation among long term care service providers. It is important to realize that there is both a shared commitment to caring and serving elderly persons through a long term care system, and general agreement that the current system is in need of change. It is realizing what the service providers have in common, rather than how they differ, that is important in coming to terms with the operational factors necessary to strengthen community-based long term care for individuals.

Following are the recommendations which emerged from each work group. Within each group, there was substantial, but not always unanimous, agreement on the vast majority of them; the recommendations for which there was not full agreement were mentioned previously. Because the full conference did not have the opportunity to review each issue area or to vote on all the recommendations, the recommendations which follow have been endorsed only by part of the conference.

ISSUES AND RECOMMENDATIONS

PLANNING AND EVALUATION - RECOMMENDATIONS FOR POLICY AND ACTION

Discussions in the Planning and Evaluation work group surveyed a multitude of areas which must be considered in planning and evaluating long term care. The recommendations are organized around three major topics: the planning process itself; tools for planning and evaluation; and the quality of life for individuals receiving long term care. It is particularly important that the focus on the individual be maintained throughout the planning and evaluation process. The work group's recommendations should be read in that light, even where they speak to institutional or regulatory questions. After all, it is the individual who suffers the concrete - as opposed to the conceptual - results of fragmented or conflicting administrative requirements.

I. Planning Process: Community Planning

- There should be plans at the federal, state and local levels which relate to each other.
- National plans should encourage state and local planning and be flexible.
- Plans at all levels should constantly be revised in light of community experience.
- There should be ongoing consumer involvement in the public planning process.
- Planning should be sensitive to the development of a balanced long term care system, including appropriate priorities for the various forms of community-based services, e.g., home care and institutional services.

II. Planning Process: Integration of Health, Social and Voluntary and Community Services

- Planning at all levels should require linkages between the several plans and systems, e.g., medical, preventive health, mental health, social and voluntary, and community services.
- Planning at all levels should address developing mechanisms and incentives that encourage linkages.
- The planning process requires integration of budget realities and the budget process.
- Planning at all levels should address the total situation of individuals, including house, income and transport.

III. Planning Process: Responsibilities at Various Levels

- At the federal, state and community levels, there should be an identifiable focal point for developing the long term care plan.

- Each focal point should be built upon existing agencies involved in planning for long term care.

- The planning process at all levels should take into account demographic, health, social, economic and political trends.

- Successful planning requires an awareness of and support from significant power sources in the community.

- At the federal level, planning should:

    - be enabling for state and local planning activities;
    - be direction-setting;
    - deal with financing;
    - deal in principles;
    - be subject to wide public review;
    - reduce redundancy among agencies;
    - have a single bureau focus; and

    support and review development of national basic quality of care standards and coordinate with other federal departments and the states with respect to monitoring these standards.

- At the state level, planning should:

    - develop state-wide needs and priorities which recognize local needs and concerns;
    - assist in developing services and funding through legislation;
    - reconcile community relationships and overlap; and
    - enhance and develop quality of care standards, devise regulatory and monitoring mechanisms, and provide coordination among various departments involved in quality issues.

- At the local level, planning should:

    - be population-based;
    - deal with multiple settings for care;
    - provide for the most appropriate form of care at the most reasonable cost;
    - deal with future trends and plan for them;
    - be based on data and facts; and
    - be implementable and feasible.

IV. Tools for Planning and Evaluation

- Effective mechanisms should be devised to collect and disseminate research and evaluation data for the assistance of planning, reimbursement and other long term care policymakers.
- There should be projects with different resource configurations, e.g., housing, institutional care, and home health care.
- Greatly increased social and technical research should be stimulated.
- Because much long term care research is fragmented and specialized, a long term care research and evaluation agenda should be devised which focuses on large-scale, integrative, cumulative undertakings.
- Existing systems of long term care delivery are frequently redundant or inadequate. To help overcome this situation, data should be improved in its commonality, timeliness and relationship to decision-making. In addition to making better use of available data, funds should be made immediately available for collecting population data based on the need for services and the supply, organization and distribution of services.

V. Quality of Life: Freedom of Choice

- Individuals should have freedom to choose whether or not to seek services or care.
- Planning should encourage creating options for individuals and exercising freedom of choice by individuals.

VI. Quality of Life: Age Integration

- There should be support for program policy and funding being age-specific to assure maximum advocacy and funding for aging programs.
- There should be support for utilizing the elderly in the delivery of long term care services to the maximum extent possible.
- Generally, there should be support for an age-integrated "delivery" system, although we recognize that not all long term care services are appropriate for age integration.
- In the short term, provide for easily obtainable waivers for administrative requirements which are different for programs supporting services for the aging, in order to facilitate the coordinated delivery of services to the elderly by providers of care.

- Work should begin immediately on removing statutory and regulatory requirements which result in differing, conflicting or wasteful administrative requirements for service programs for the elderly.

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Work Group Vice Chairperson: Donna Melkonian, Director, Office of Aging & Long Term Care, American Hospital Assn.
Work Group Recorder: Frank E. Samuel, Jr., General Counsel, Home Health Services & Staffing Association
Work Group Assistant Recorder: David C. Crowley, Executive Vice President, American Association of Homes for the Aging

PROGRAM AND CASE MANAGEMENT - RECOMMENDATIONS FOR POLICY AND ACTION

There was a consensus that a component of the long term care delivery system include a case management function.

Overall Philosophy

The central focus must be on the individual, his or her rights and entitlements, and protection of maximum opportunity for maintaining independence and dignity. The system should be designed to meet the changing needs of the individual in the most appropriate manner. We must zealously avoid actions that result in forcing individuals to serve the system as contrasted with our concern that the system focus on most effectively serving the individual.

Issue Categories Defined by Work Group

- Purpose/Goal of Case Management
  - for individual
  - for system/for community
  - access
  - health and social service
  - physical
  - mental
  - continuum

- Client Group for Case Management
  - categorical
  - functional

- Informal Supports
  - cultural application
  - natural supports
  - "surrogate" supports
  - relationships between formal and informal systems
  - nurturing the caretakers

- Auspices
  - "who does it?"
  - provider of services
  - service management organization
  - public vs. private

- Relationship of Case Management to Direct Service
  - health and social services

- Client Control
  - program design
  - consumer education: individual and community-wide
  - provider education

- Standards/System Control
  - supervision
  - accountability

- Financing/Legislation

I. Purpose/Goal of Case Management

- Purpose of case management: to assist or advocate on behalf of functionally-impaired adults to gain access to and to maintain an appropriate and acceptable set of services which are available in the least restrictive environment possible; support and develop services from informal and formal community-based resources.

- Functionally-impaired adults: adults whose personal, social or functional condition requires assistance on a sustained basis.

- Definition of case management: Case management is composed of an interdisciplinary process of needs/conditions assessment, case planning, arranging for coordination and monitoring services. This includes advocacy to fill gaps, allocation of resources and provides for the patient to participate in and determine his/her own plan of care.

II. Characteristics of a case management system should include:

a. Operating procedures which ensure the right of the consumer to:

  - preserve their individuality and independence in the plans of care;
  - participate in the development of the plan;
  - accept or reject or refuse to participate in care plan;
  - have access to information about their own care plan;
  - choice in available service providers;
  - protection from abuse or neglect (guarantee of care quality);
  - representation by family, friends or advocates (formal and informal), if desired by client; and
  - client confidentiality.

b. Access to a case management system should be an entitlement of all adults, regardless of their income and need for service.

c. Case management includes an oversight function which assures that all services meet recognized standards of care and which holds the provider accountable for quality of service.

d. Potential users of services should be involved in the planning and development of new case management systems and operating procedures should be established for hearing personal grievances.

e. Service providers necessary to the continuum of long term care should be involved in the development and implementation of case management systems.

III. Services to be provided:

The White House Conference on Aging should incorporate a process through which they define what services should be provided in the continuum of care.

IV. Standards/System Control

Broad guidelines for program services and case management standards should be developed at the federal level for standard-setting by each state, in order to preserve quality of life, safety and health of the individuals receiving services. Each state should designate a lead agency responsible for developing standards and monitoring methods. Both service and case management standards should include a provision for local community oversight and quality control.

V. Auspices

By 1985, all states should be required to designate and develop functioning case management systems as defined below.

Case management should be provided in a manner which ensures that plans are developed without a bias for a particular service. Case management models include, but are not limited to:

- an independent organization whose sole purpose is to provide assessment, general services planning, coordination, monitoring and in some cases, funding. It does not provide services, but provides a single entry point to a vast array of services.
- an independent organization which arranges for and coordinates assessment, case planning, monitoring and reimbursement activities for individuals needing long term care.
- a comprehensive service provider which has a separate unit which does the above.
- a consortium of service providers which does the above.

No single model should be mandated nationally.

Existing patient review and other regulatory mechanisms should be examined and revised to avoid duplication and to support the development of a system which increases options for meeting individual needs and which encourages providers to continue to improve quality of service without diverting energy and resources to compliance issues.

VI. Informal Supports

Case management should be conducted in a manner that preserves and/or strengthens the independence of clients and their informal supports.

VII. Client Control

There should be a concerted effort made and funds allocated to educate the consumer, provider and policymaker as to the purposes and advantages of case management.

VIII. Financing/Legislation

All federal and state agencies responsible for Titles XVIII, XIX, and XX of the Social Security Act, and Title III of the Older Americans Act, should be required to finance service plans developed through designated case management systems for long term care. The reimbursement system should provide equitable funding for a complete continuum of care.

Work Group Chairperson:	Harvey Wertlieb, Administrator, Randolph Hills Nursing Home, Wheaton, MD
Work Group Vice Chairperson:	Donna McDowell, Director, Wisconsin Bueary on Aging
Work Group Recorder:	Jane Brennan, Assistant Director, Council of Home Health Agency Community Health Services of the National League for Nursing
Work Group Assistant Recorder:	Kaye White, Associate Director, Education, American College of Nursing Home Administrator

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ORGANIZATION - RECOMMENDATIONS FOR POLICY AND ACTION

Issue Categories Defined by Work Group

- There is a societal responsibility to assure that vulnerable elderly have access to a community care system which provides assistance to individuals in need and which builds upon the strengths of informal supports, such as family and friends: and maximizes the independence and self sufficiency of individuals receiving care.

- The community care system must be appropriate to the community and therefore, any recommended models must have flexible structures which can adapt to unique local factors.

- The system should encompass the broad array of health and social services needed by older persons, which can be provided by families, and private and governmental agencies.

- Assessment of needs can be done by the individual; family member or friends; a service provider; and a case manager.
  - A person with multiple needs may require the assistance of family members, friends, or a case manager in arranging for needed service.
  - The views of the individual should be recognized as the most important factor in determining the services which he/she receives.
- Prevention (timely intervention on behalf of an individual) is an integral component of a community care system.
- Community care organizations have multiple functions. These include:
  - assuring the availability of a comprehensive continuum of care for vulnerable older persons;
  - addressing the issues of cost containment in order to maximize the efficient utilization of long term care resources; and
  - coordinating the provision of community care.

RECOMMENDATIONS

I. Planning and coordinating mechanism within a community must be present which:

- embraces a full range of health and social services including informal support networks; and
- enters into contracts and agreements with agencies and organizations for the provision of direct services.

The community organization which functions as the planning and coordinating mechanism would be designated by the state, considering local recommendations. In defining the geographic area covered by the planning and coordinating organization, consideration must be given to:

- the boundaries of local government;
- coterminus boundaries with other planning functions; and
- an optimum size for administrative efficiency in relationship to population and geographic factors.

II. A community care system developed by the planning and coordinating mechanism must include the following four elements:

- referral sources
- linkage system, including
  - outreach
  - screening and assessment
  - care planning/management
    - case management
    - service management

    - care implementation
    - evaluation
- an array of health and social services
- monitoring procedures

III. The array of services needed within a community should be based upon local determination.

IV. Reimbursement policy for services must follow planning policies:

- Individual need should define reimbursement policies. This requires a restructuring of many existing funding mechanisms.

V. Individual need for services should be based on:

- functional ability
- current living arrangements
- supports available from the family, significant others
- ability to pay

VI. The planning and coordinating mechanism needs access to broader entitlements for Titles XVIII, XIX, X and Older Americans Act for client services.

VII. Three major functions must be implemented in order to:

- plan
- develop linkages
- deliver long term care services

The agency which conducts the functions of system planning and system coordination should not be a direct provider, if at all possible. The functions of the linkage system can be carried out either by the planning and coordinating agency, a direct service provider, or other community entity.

VIII. There should be established an ongoing joint planning process between the area agency on aging and the health systems agency. The planning process should be client-oriented, and address the whole range of health and social services, and provide for broad community input. It should address the development of a comprehensive health and social service system. The plan will address the establishment of a service linkage system in the community. As part of this plan, the AAA and HSA will come to an agreement regarding the specific areas or issues which will be assigned to each agency for lead responsibility, and make recommendations on those responsibilities which might be assumed by other organizations. The plan will also lodge clear responsibility for system monitoring.

Work Group Chairperson:	Lou Glasse, Director, Office on Aging, Albany, NY
Work Group Vice Chairperson:	Peter Meek, Board Member, National Council on the Aging, Inc.
Work Group Recorder:	Diane Justice, Senior Policy Associate, National Association of State Units on Aging
Work Group Assistant Recorder:	Monna Kohn, Special Assistant for Communications American Health Care Association

HUMAN RESOURCES - RECOMMENDATIONS FOR POLICY AND ACTION

The work group on human resources identified the following issues on human resources and the delivery of long term care. The issues were prioritized into the following order:

- manpower
- education and training
- community resources

Recommendations for policy on each of the issues were discussed. Some were agreed to by a consensus; others were the subject of substantial disagreement.

Issue: There currently exists a shortage of manpower to deliver long term care services.

RECOMMENDATIONS

I. The supply of professionals, para-professionals, volunteers and otherstrained to deliver long term care services should be increased by:

- encouraging high schools, vocational schools, junior colleges and universities to provide programs to train personnel to deliver long term care.
- utilizing the established long term care system in the training of physicians, dentists, nurses, social workers and others in the delivery of long term care services.
- increasing support for graduate programs for those who deliver long term care services.
- increasing the attractiveness of employment in the long term care system by:
  - articulation of career ladders and educational paths that provide incentives for the improvement of skills and career advances.
  - establishment of benefits and compensation commensurate with those provided by other sectors of the health care delivery system.

- supporting the use of technology that assists in the delivery of long term care services. For example, "ambulatory monitoring" and "lifeline systems" can be used in some cases for providing for a more efficient use of health manpower.

The following recommendation was the subject of substantial disagreement among the members of the work group:

- encouraging support for the continuation of the three-year nursing school programs.

Issue: There is a need for an expanded emphasis on education and training in the delivery of long term care services.

RECOMMENDATIONS

I. More education of potential consumers to the options available for long term care services should be provided.

II. More education of potential providers to the options available for career and employment opportunities in the long term care system should be provided.

III. Gerontology and geriatrics should be included in the curricula of the educational system, from early grade school through graduate schools.

IV. The education of long term care providers should give greater attention to the psycho-social and cultural needs, as well as the physical needs of patients.

V. General (federal, state and community) education funds should be tapped to provide for education about long term care.

VI. Providers of long term care should offer in-service training for all employees, volunteers and other interested people.

VII. Long term care providers' manpower training costs should be established as reimbursable costs.

VIII. Biomedical research on the aging process should be promoted.

IX. Incentives should be established that encourage providers to offer community education on the total spectrum of long term care.

The following recommendation was the subject of substantial disagreement among the members of the work group:

- Proprietary organizations should be eligible as sponsors of and participants in federally-funded training programs.

Issue: The planning, management and delivery of long term care services should include the involvement of community resources.

RECOMMENDATIONS

I. The supply of human resources involved in the delivery of long term care should be enhanced by providing tax credits, commensurate to business tax credits, to volunteers.

II. The supply of human resources in the delivery of long term care services should be enhanced by providing tax credits to families providing long term care in the home.

The work group on human resources passed the following motion:

That the White House Conference on Aging Technical Committee on Long Term Care, in their consolidation of the various work groups, take into consideration the need for a more specific definition of long term care.

Work Group Chairperson: M. Joe Helms, Executive Director, Moody House, Galveston, TX
Work Group Vice Chairperson: Dell Hagan, President, American College of Nursing Home Administrators
Work Group Recorder: Kathleen O'Donoghue, Health Programs Specialist, American Health Care Association
Work Group Assistant Recorder: Bill Halamandaris, Executive Director, National Association of Home Health Agencies

FINANCING - RECOMMENDATIONS FOR POLICY AND ACTION

Preamble Statement

"The Financing Work Group of the Long Term Care Mini-White House Conference on Aging recognizes that the current approach to financing long term care services has created a fragmented system, and that the total resource capacity is inadequate. We, therefore, urge movement toward a balanced system, i.e., the appropriate use of non-institutional as well as institutional services, and support the adequate resources, both public and private. We believe that there should be a continuum of support as well as a continuum of care."

Issue Categories Defined by Work Group

- Financing dictates services and structures and has, therefore, caused gaps as well as duplication of services.
    - Medicaid, by being considered "welfare," has influenced the way in which we treat people under that program.
    - There is bias in treatment, depending upon funding source.
- The funding system has prevented access to appropriate care.
    - There in unequal availability of the kinds of services which may promote dependence on one part of the system (e.g., family, institutions, etc).
    - Uniform reasonable cost reimbursement does not exist throughout the states for institutional and home care.
    - There is a problem of a backup of patients in hospitals which further aggravates the access to long term institutional and home health care.
    - There is a mismatch in the program benefits of Medicare and Medicaid as to their funding of services.
    - Deeming and spending-down of one's assets causes access problems to the long term care system by recipients.
    - Funding sources have tended to create a bias in the system toward an emphasis on institutional care.
    - Keeping people in their own homes as long as is physically possible is a desirable goal which must be recognized in the funding mechanisms.
- Financing limits the type of care as well as who receives that care.
    - The technology of assigning costs has not been well developed.

- There are no agreed-upon preventative entry points (assessment/case management functions) into the system.
  - Access and coordination of services does exist in some places, but not in others.
  - Should case management be available to all?
  - Are we willing to pay for all to use case management?
- There are roles for various sources of funds for long term care, but there is an imbalance in the current system.
  - There is a role for informal networks (family, friends, neighbors) in the provision of long term care, and we should support and recognize this, but in what way? How do we not abuse this informal system?
  - Medicare and Medicaid are both entitlement programs, but neither is viewed as an effectively working program.
  - There is a lack of interest by private insurance carriers to fund long term care services.
  - Client choice is an issue as to whether it is to be maintained and if so, how, as well as to what extent?
  - There is also the issue of whether we are discouraging people from saving to care for themselves, thereby encouraging indigency and a financial dependency on the public system.
- Should there be an assessment for private pay as well as public pay clients?
  - Should there be control over where the patient/client goes, based upon the assessment?
  - Who should pay for the assessment?
  - Assessment should be as early as possible in the process, not just prior to a person's entering an institution.

RECOMMENDATIONS

I. We recommend the establishment of a comprehensive, coordinated long term care system characterized by consistent eligibility criteria, benefits, and reimbursement on an equity basis for all noninstitutional services.

II. We recognize assessment and case management as a national strategy wherein the assessment mechanism serves as the allocator of reimbursements, etc.

III. Alternative reimbursement policies must be developed for long term care service payments such as HMO capitation payments, voucher reimbursements, etc.

IV. We must utilize effective structures at the local level for the planning and delivery of long term care services and case management, allowing for community flexibility which, to the extent practical, utilizes existing structures.

V. Pension policies must reflect the potential for revision of an insurance mechanism for long term care through pooling of pension structures.

VI. Different ways to meet the need for capital (all capital, not just for the construction of institutions, but for operational costs of services) in developing the long term care spectrum of services needs to be examined, and the effect of adequate and consistent reimbursement on capital formation policies be considered.

VII. Options for encouraging the development of private insurance coverage for long term care services must be explored.

VIII. Maintenance and enhancement of informal networks (family, friends, neighbors) must be considered in the development and financing of a long term care system.

IX. Quality of care must be assured in the payment of long term care services.

X. Efforts must be initiated for developing alternative definitions for long term care, based upon various scenarios for resource allocation, need characteristics of at-risk populations, service capacities, with steps taken to develop economic models for determining trade-offs of income, housing and service policies.

Work Group Chairperson: Jack MacDonald, Executive Vice President, National Council of Health Care Services

Work Group Vice Chairperson: Elsie Griffith, Director, Visiting Nurses Association of Dallas, TX

Work Group Recorder: Kay Samec, Area Agency Liaison, National Association of Area Agencies on Aging

Work Group Assistant Recorder: Kevin Hickey, Special Assistant to the President, American Hospital Association

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Mini-Conferences have been recognized by the 1981 White House Conference on Aging and convened by organizations that wished to focus attention on special aging issues.

Recommendations of mini-conferences are not the recommendations of the official delegates to the Conference or the U.S. Department of Health and Human Services. They represent the views of the participants in the mini-conferences. They are being made available to the delegates as part of their background materials for the national conference.

The following Mini-Conference Reports have been published:

Recreation, Leisure and Physical Fitness
Aging and Alcoholism
Energy Equity and the Elderly
Public/Voluntary Collaboration: A Partnership in contributing to independent living for the aging
National Health Security
Concerns of Low-Income Elderly
Vision and Aging
Alzheimer's Disease
Arts, the Humanities and the Older Americans
Older Women
Life-Long Learning for Self-Sufficiency
The Urban Elderly
Rural Aging
Long-Term Care
Non/Services Approaches to Problems of the Aged
Spiritual and Ethical Value System Concerns
Transportation for the Aging
American Indian/Alaskan Native Elderly
Pacific/Asian Elderly "Pacific/Asians: The Widsom of Age"
Environment and Older Americans
Rights of the Institutionalized Elderly and the Role of the Volunteer
Veterans
Mental Health of Older Americans
Saving for Retirement
Hispanic Aging
Challenging Age Stereotypes in the Media
Oral Health Care Needs of the Elderly
Housing for the Elderly
Consumer Problems of Older Americans
Senior Centers
Elderly Hearing Impaired People
Black Aged
Legal Services for the Elderly
Simplifying Administrative Procedures and Regulations in Programs Affecting the Elderly
Intergenerational Cooperation and Exchange
Self-Help and Senior Advocacy
Euro-American Elderly
Inter-relationship of Government, Private Foundations, Corporate Grant-Makers and Unions
"The National Dialogue for the Business Sector"
Foot Health and Aging
Pacific Islanders Jurisdiction
Gerontological Nursing

The 1981 White House Conference on Aging
Report of the Mini-Conference on Aging and Alcoholism

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Council
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Alcoholism inc. Public Policy Office
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BLUE RIBBON STUDY COMMISSION ON ALCOHOLISM AND THE AGING

INTRODUCTION

Recognizing that a significant number of older Americans suffer from alcoholism and alcohol-related problems, and are without the help that they need, the Blue Ribbon Study Commission on Alcoholism and Aging of the National Council on Alcoholism, convened a Mini-Conference on Aging and Alcoholism on February 1-3, 1981, at the Wingspread conference facility provided by the Johnson Foundation of Racine, Wisconsin.

The Blue Ribbon Study Commission on Alcoholism and Aging of the National Council on Alcoholism was established as a means of directing national attention to the problem of alcoholism and alcohol abuse among the nation's aging population. Participation in The 1981 White House Conference on Aging is one of a number of activities planned by The Commission to accomplish this goal.

The conference brought together decision-makers in both the fields of aging and alcoholism -- representatives of private and public sectors, all levels of government, business, labor, voluntary agencies, educational systems and private industry. The Mini-Conference on Aging and Alcoholism was designed as a working conference. Each participant was assigned to one of five work study groups: (1) the elderly alcoholic in the residential long term care facility; (2) the elderly alcoholic in the non-residential community based aging program; (3) the elderly alcoholic in an urban environment; (4) the elderly alcoholic in a rural environment; and (5) the elderly alcoholic in the alcohol services system.

Through this conference, policy recommendations and action strategies on the alcoholism service needs of aging people and their families were developed in the form of recommendations to the White House Conference on Aging.

RECOMMENDATIONS OF THE MINI-CONFERENCE ON AGING AND ALCOHOLISM

. A national task force should be established to coordinate research on the effects of alcohol and the aged.

. Information campaigns must be developed to inform the public that aging persons can experience serious alcohol problems and that they can and should be treated for those problems.

. Model training programs are needed to increase the awareness and skills of persons working within the aging and alcoholism services systems to aid them in the detection of alcoholism and alcohol-related problems.

. Incentives should be provided to medical schools to carry out a plan for education on alcoholism and drug misuse within the context of geriatric medicine.

. Strategies must be developed to improve coordination among agencies and service delivery systems in both the public and private sectors that deal with the problems of aging and alcoholism.

. Area Agencies on Aging should serve as the local coordinating bodies between the public, private, and voluntary agencies concerned with aging and alcoholism.

. Inventories of formal and informal service and case-finding networks in rural areas must be conducted to help identify the aged alcoholic.

. The National Institute on Alcohol Abuse and Alcoholism (NIAAA), in cooperation with the Administration on Aging (AOA), and the National Institute on Aging (NIA) should develop guidelines and quality control measures for the aging alcoholic.

. Voluntary Senior Citizen organizations should be involved in the prevention, education and identification of alcoholism and alcohol-related problems among older people.

. Legislation and regulations which restrict appropriate alcoholism treatment for aging persons must be revised and financial barriers to care eliminated.

. Governmental and private organizations must recognize the strength of the voluntary and informal networks in the treatment of the aging alcoholic.

. Prescription drugs should be labeled to warn about the effects of combination with alcohol.

- Model programs capable of replication in many communities must be developed by The National Institute on Alcohol Abuse and Alcoholism and The Administration on Aging to demonstrate coordinated approaches to alcoholism services for aging persons living in urban areas.
- Cities should consider the establishment of an interagency council to address the alcoholism service needs and available resources for aging people.
- The rights of aging alcoholic patients must be recognized and protected.

THE POPULATION

Minimum estimates of the percentage of aging persons who experience alcoholism and significant alcohol-related problems are imprecise. Conservative estimates put the current figure at 3 percent of the total population, or about 800,000 persons. The significant point is that if the percentage is held constant, the total number of such persons will increase dramatically. This will strain the resources available to treat alcoholism and its attendant disorders.

A range of estimates exists as to what constitutes alcoholism and significant alcohol-related problems among aging people. In spite of the incomplete understanding of the disease itself, along with the variation in its physical, behavioral and social manifestations, meaningful definitions do exist, but their acceptance is not yet universal.

Despite the wide variation in estimates of incidence, several concepts relevant to the recommendations contained in this report are agreed upon among professionals closest to the problems of alcoholism and aging:

- First, it is generally accepted that there are two groups of aging alcoholics, distinguished by the time of onset of the disease. The early onset group, those who became alcoholic before age fifty, comprises about two-thirds of all aging alcoholics. Onset in the remaining one-third occurs at or after age fifty. It is believed that much of the late onset alcoholism is triggered by situational factors, such as actual or impending retirement, increased leisure and loss of loved ones.

- A second generally acknowledged fact is that as people age they consume less alcohol. Caution must be exercised in drawing conclusions about alcohol problems based on the decrease in consumption of alcohol with age. While per capita consumption declines with age, several factors suggest that some problems become more serious with age. For example, the older person has a lower tolerance for alcohol, and the fragility of their social network makes them more vulnerable.

- Although epidemiological estimates are difficult to obtain and require cautious interpretation, the clinical and social observations of persons who work with the aging suggest that alcoholism and alcohol-related problems are much greater than is commonly acknowledged.

- Many alcoholics who have been successfully treated may become part of the available health care network resources. Thus there potentially exists a rich source of people capable of contributions to both the fields of alcoholism and aging. These contributions may include skills such as clinical aspects of alcoholism treatment, program and financial management.

CONSIDERATIONS FOR THE IDENTIFICATION AND TREATMENT OF THE AGING ALCOHOLIC

One consideration in the treatment of alcoholism and alcohol-related problems in any population, and especially among the aging, is that they can be successfully treated. Further, many clinicians affirm that aging people respond more positively to treatment than many of their younger counterparts.

In developing the treatment approach to an older person, it must be understood that the aging are a vulnerable group. They are vulnerable not only in experiencing alcoholism and alcohol-related problems, but also for developing complications associated with the aging process and the disease of alcoholism.

There are a number of factors which have been associated with problems related to alcoholism among aging persons.

- First, the aging as a group are likely to encounter situations that are known to contribute to an onset of problem drinking. Retirement, unrewarding increased leisure, and physical and social isolation are all potential threats to the maintenance of self esteem. These situations may trigger destructive behaviors such as problem drinking.

- Similarly, in later life, people are more likely to encounter grief and loneliness. The death of a spouse, family member or close friend have been cited as contributing to drinking problems. Since nearly twice as many women survive beyond the age of 65 as do men, women may be particularly vulnerable to the onset of alcoholism as a result of loneliness and grief. Professional opinions indicate that alcohol affords temporary relief from the pain of loneliness, self-doubt, and fears. This observation is congruent with the observation that socialization can be effective in treating alcoholism.

- Twenty-five percent of all prescription drugs are consumed by the aging. Many of the drugs are known to interact adversely with alcohol. More needs to be done to educate or warn the aging about such dangers.

- Alcohol consumption as well as the aging process decrease sensory and motor functions. This leads to a higher probability of accidents, and thus a greater utilization of health care resources.

- Alcohol abuse also interferes with proper nutrition. This problem is especially serious for the lower-income aging whose nutritional status may already be marginal. Not only does alcohol disrupt the appetite, but the redistribution of the food budget to cover the cost of drinking frequently results in reduced or less nutritious food consumption.

- Aging persons with alcoholism are also at risk of going undetected or untreated. Many aging persons and their families, especially those closest to the alcoholic, deny their alcoholism. The social stigma of alcoholism persists despite considerable efforts to eliminate it.

- The signs and symptoms of alcoholism are similar to those of other diseases, such as senile dementia and gastritis. A person who is incorrectly diagnosed as suffering a disease other than alcoholism may be subjected to inappropriate treatment.

- The nature of the disease simply makes it difficult to diagnose. In addition, the training of health professionals tends to be fragmented and to offer insufficient academic role modeling in both alcoholism and gerontology. Consequently, even those aging persons with alcoholism who are in contact with the health and social service delivery systems stand a good chance of remaining undiagnosed.

- Those alcoholics who have little contact with health and social service professionals and few social supports are most likely to go undiagnosed. This applies particularly to isolated populations, such as the rural elderly and the homebound.

Once the problem of alcoholism is detected by health care personnel, treatment must be multifaceted. The importance of this point cannot be overemphasized. Treatment should attend to the total scope of the patient's alcohol-related needs. This should include attention to the psychological, social, financial and transportation needs of the individual. Alcohol and alcohol-abusing patients will require the mobilization of this entire array of services to provide comprehensive and effective treatment.

The need for treatment places a large responsibility on the health care and social services delivery systems for coordination of services to the aging. The difficulties of coordination are compounded by the diversity of the organizations involved and their inherent tendency to separate their functions into discrete, specialized units. Coordination among specialized organizations is likely to be difficult, but effective treatment is not likely without it.

Although the family is a viable force in treatment of the older alcoholic, in many cases it is not a positive force. Researchers and clinicians most knowledgeable about the role of family in treating alcoholism say that a portion of the aging alcoholics are alienated from their families. Family embarassment and exasperation after unsuccessful interventions contribute to the alienation of alcoholics from their families. In addition, an increasingly large percentage of the aging have no surviving family at all.

In instances in which the family is available it may be a very effective vehicle for fostering the rehabilitation of the alcoholic. Attending agencies must actively attempt to incorporate the family in treatment whenever possible. When this is not possible the agency must assume the role of building alternative social support structures.

Not only must the treatment of alcoholism be comprised of a full complement of treatment-related services, but these services must be continued after the completion of formal treatment. Practicing clinicians report that to let an alcoholic return unaccompanied by continuing medical and support services to the setting from which he or she came is to invite an undoing of previous progress. The firmly established importance of continued treatment means that health care insurors and legislators who shape health legislation need to consider revisions in eligibility and reimbursement policies for treatment of the older alcoholic. Revisions which would provide reimbursement for medical and non-medical long-term care for alcoholism will be cost effective.

Finally, the adage that an ounce of prevention is worth a pound of cure is especially true for alcoholism and alcohol-related problems among the aging. There is difficulty in identifying vulnerable persons, because the requirements for treating alcoholism are better understood than are the means of preventing it. However, if the nation is to overcome the disease of alcoholism and its attendent toll on the health of society, great strides in research are needed in both diagnosis, treatment and prevention.

SOME PROBLEMS WITH CURRENT TREATMENT APPROACHES

Like any profession, medicine and gerontology must operate with less than perfect information. This is especially the case in treating alcoholism. Alcoholism is simply not well understood. Clearly, more research on the nature of the disease and effective treatment is in order. Further, what good information is available has not been incorporated in the day to day business of treating alcoholism and caring for alcoholics. Similarly alcohol information has not been incorporated into the senior services systems.

Though a full range of well-integrated services appears to be critical in treating alcoholism, the existing network appears to be highly fragmented, if not in structure, at lease in function. Part of the fragmentation derives simply from professionals' failure to recognize how critical it is to surround the client with related support services. This may result in the failure to make appropriate referrals.

In some other cases, fragmentation results from a lack of necessary services. Rural populations, for example, because of a lack of transportation and locally available services, do not have even the minimum essential treatment services. Even in the long-term residential care facilities for aging, where the opportunity and setting for treatment would appear ideal, alcoholism often goes untreated. Such facilities are usually geared, operationally as well as philosophically, to custodial rather than rehabilitative care. In cases where they may wish to provide other treatment, they are frequently constrained by Medicare or other health insurance reimbursement regulations.

Those alcoholism treatment programs that do exist, even those that are coordinated in their operations, generally treat alcoholics who self identify or who are referred by legal or health agencies. Practically no attempt is made to identify the untreated alcoholic. The combination of this minimal outreach with detection difficulties posed by the disease and the general tendency for denial provides a high probability that the aging alcoholic will go untreated.

One obstacle to professionals' efforts to treat alcoholism is the restrictive reimbursement policies and regulations of private and public (including Medicare) health insurers. The overwhelming opinion among professionals working in the area of alcoholism and the aging is that a continuum of care or "aftercare" is crucial for successful treatment. Yet, many of the related support services are not reimbursable under existing regulations. In fact, many alcoholics will be treated as inpatients simply because out-patient care is not reimbursable.

Most of the aging alcoholic population cannot afford the cost of care over the time period typically required for effective treatment. Legislators and primary health insurers are going to have to re-think what is in the best long-term interest of this population and of this country.

The larger, more nationally prominent and prestigious professional groups and federal agencies as a group have recently begun to acknowledge alcoholism among the aging as a national, high priority problem. More needs to be done by both governmental and voluntary agencies and organizations.

RECOMMENDATIONS

The following recommendations made by conference participants in the various work study groups have been regrouped into six broad categories that lend themselves to consideration and action by policy makers. The six categories are: research and development; education and training; increasing the utilization of existing services; ensuring and improving the effectiveness of treatment; increasing the availability and access of services; and protection of patients' rights.

In general, the recommendations involve relatively little additional expense. For example, no new agency is proposed. For the most part, the recommendations call for modifications or extensions in existing programs and legislation. Generally, the recommendations are relevant to all aging groups, with the exception of some recommendations aimed primarily at increasing or improving services to elderly persons living in rural areas.

Research and Development

Participants who identified research and evaluation as a priority noted the problems of a growing aging population and an inadequate level of services within existing treatment systems as the rationale for research specifically targeted to the needs of this population. Recommendations for research and development on aging and alcoholism focused both on organizational and funding strategies.

Organizationally, it was recommended that a national task force for research on aging and alcoholism be established, through a prestigious organization such as the National Academy of Science. This task force would be responsible for determining the kinds of case discovery, differential treatment, rehabilitation, and continuity of care that are appropriate for this growing population.

Several broad areas in which research on aging and alcoholism should be conducted include: (a) metabolic/physiological aspects of alcoholism among the aging; (b) the kinds of alcohol abuse found among the aging (including the late onset of alcohol abuse and the continuation of drug patterns established at an earlier age); (c) treatment models and their effectiveness; and (d) the interaction of alcoholism, psychological, and socioeconomic factors, including both the effects of alcoholism on life events and the reverse.

The Federal Government, through its appropriate agencies, was identified as having responsibility for funding and monitoring research and evaluation activities. Private organizations were also identified as a funding source, particularly for research on the effectiveness of various treatment models.

The following sequence of research activities was recommended: the establishment of research priorities and funding to evaluate appropriate treatment models, by May 1982; the planning and implementation of a series of "best practice" seminars to disseminate research findings, by April 1983; the development of a mechanism for incorporating effective treatment models into the system for practitioner training, by April 1984.

Education and Training

There is a need for education and training related to alcohol and the aging. This can be achieved through public information and education on the prevention and treatment of alcoholism and alcohol related problems of the aging; staff training; and the education of aging clients or patients and their families.

An immediate need was identified for public information campaigns to publicize the fact that aging persons do have alcohol problems and that they can and should be treated. There is a need to emphasize that alcohol is a leading, or at least contributing, cause of death among the aging. Speakers bureaus, outreach efforts, and the labelling of prescription drugs to identify their dangerous interactions with alcohol, were recommended as specific strategies for inclusion in public information and education efforts.

Development of model training programs was recommended in order to increase the awareness, knowledge, and skills of staff with respect to the detection and diagnosis of alcoholism and alcohol-related problems, including the needs of special populations. Model training programs should be developed to incorporate existing and new alcohol related content.

Training programs would require the development of educational materials and curricula that address the problems of alcohol and the aging. Although training programs, especially inservice training, may be a local responsibility, public and private organizations at the national and state levels, including professional organizations, were identified as having the lead responsibility. For example, it was recommended that NIAAA, in cooperation with HRA, AOA and NIA, develop a contract for the development of curriculum guidelines to be available to all such programs, and that this should occur by June 1982.

The need for incorporating new research findings into training materials and programs was also identified. Taking into account the timelines for implementing research and evaluation priorities, this should occur by April 1984.

Training should include the education of physicians and other health care personnel with regard to alcoholism, alcohol abuse, and the interactions of alcohol with other drugs and the associated dangers. It was specifically recommended that incentives be provided on both the federal and state level, to medical schools to implement a plan for education on alcoholism and drug abuse, with specific reference to geriatric medicine.

The education of the aging clients or patients and their families with respect to alcohol and its abuse was identified as a responsibility of the staff of institutions serving the aging. Such staff members would include physicians and other health care personnel, as well as counselors and other professionals and paraprofessionals who provide services to the aging. Education aimed at involving patients and their families in alcohol treatment program activities and the formation of support groups were suggested strategies.

Increasing the Utilization of Existing Services

Recommendations for increasing the utilization of existing services emphasized strategies for improving coordination and linkages among the various agencies and service delivery systems that deal with problems of the aging and with alcohol abuse and treatment. For example, at the national level, NIAAA should provide inventories of alcohol treatment services to the leadership of aging, social welfare, transportation, and health systems in each state. At the state level, a state alcohol authority should provide inventories of alcoholism treatment programs and services to local directors of systems providing services to the aging. At the local level, the training of service delivery staff should include facilitating the entry of aging persons into alcohol treatment programs. State and local plans for inter-system policy should be developed and implemented.

Recognizing the problem of fragmentation of services (e.g., health and social services), it was recommended that Area Agencies on Aging (AAA) serve as the local coordinating bodies between the public, private, and voluntary sectors. AAA's should promote linkages between the aging network and the health delivery and alcohol-drug dependency networks to ensure optimal use of the expertise and resources of each for the benefit of the aging.

An example of a specific mechanism suggested for accomplishing better planning, development, and coordination of services is an "interagency council" at the local municipal level consisting of representatives of alcoholism and aging providers. Responsibilities of this council would include the assessment of available information defining the alcohol-related problems of the aging in the community and preparing an action plan for the city and/or county government.

A particular need was identified for creating local inventories of relevant formal and informal resources in rural areas. It was recommended that a methodology for creating such inventories be developed and made available to other local communities.

Ensuring and Improving the Effectiveness of Treatment

A general recommendation for assuring the effectiveness of all alcohol treatment programs serving the aging was that NIAAA, in cooperation with AOA and NIA, should develop guidelines for quality and scope of treatment of the aging alcoholic.

Treatment programs must recognize that aftercare is important and make provisions for it. A specific recommendation was that the involvment of the "recovering community" and older persons be stimulated through the expansion of support and self help groups.

There is a need for a high quality, low cost model program providing comprehensive services to the older person with alcoholism, utilizing and integrating existing public and private health, aging, alcoholism, and mental health services. It was recommended that the President direct NIAAA and AOA to include the development of such a model in their authorizing legislation with the support and cooperation of NIA and the Health Care Financing Administration (HCFA). The proposed program would include attention to the needs of special populations, housing patterns, outreach, family roles and needs, and funding strategies. Simplified guidelines should be developed for general use in other communities.

There is a limited range of services available in rural areas. Service providers frequently lack the requisite knowledge and skills to serve aging alcoholics and existing services tend to be fragmented. Therefore, treatment alternatives should be developed that are relevant to the conditions of the rural alcoholic and that ensure a continuum of care.

Increasing the Availability and Accessibility of Services

Senior citizen organizations should be used for the prevention and identification of potential and actual alcoholism. Some training may be necessary to facilitate identification and referral to an appropriate agency for assessment and treatment, including aftercare. Kinds of problems to be identified include long-term alcoholism and later onset alcoholism, and alcohol-related problems including adverse effects of interactions with other drugs, falls, fires and highway safety for both drivers and pedestrians.

Restrictive and conflicting legislation and regulations that prohibit or present obstacles to appropriate care for aging persons must be eliminated. Implementation of this recommendation requires the assessment and amendment of legislation and regulations -- at the national, state, and local levels -- that affect patient eligibility and entitlements, service delivery, or reimbursement of services.

Governmental and private organizations should recognize the potential contribution of the voluntary and informal network in the comprehensive treatment of the aging alcoholic.

Protection of Patients' Rights

Even with the best intentions and the most beneficial services, individuals or organizations may, in an overzealous pursuit of their missions and goals, intervene or attempt to intervene in personal and family lives in a way that could violate human or legal rights.

Appropriate safeguards to prevent this include, (1) the development and training of a volunteer ombudsmen to serve on behalf of aging patients, (2) the inclusion of patients' rights material in all training material where relevant, and (3) to establish local review boards to evaluate adherence to patients' rights.

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the 1981
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Report of
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Foot Health and Aging

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Foot Health

Introduction

In cooperation with the Pennsylvania College of Podiatric Medicine and the American Podiatry Association, the James C. Giuffre Medical Center, Philadelphia, Pennsylvania, hosted on March 7 and 8, a Special Clinical Mini-Conference on Aging. Attended by 198 health professionals, the conference focused on the elderly's special foot health problems, particularly those associated with systemic disease. This report summarizes the proceedings of those two days' lectures and deliberations.

Aging and the Pedal Extremities

To better understand the importance of foot health in the care of elderly people, it is necessary to briefly consider the wide variety of changes which take place in the human foot due to disease and aging.

The skin is one of the first structures to demonstrate changes. The earliest sign is usually the loss of hair along the outer side of the leg and on the dorsum of the foot. Brownish pigmentations follow with an associated increase in the presence of hyperkeratotic areas due to keratin dysfunction. Added to this, some loss of muscle mass and soft tissue in the foot occurs. The nails have a tendency to become thickened and brittle and onychomycosis seems to be more prevalent.

There are numerous changes in the musculoskeletal structures of the foot. Due to wear and tear, repeated trauma, years of abuse and decreasing arterial supply, the feet are easily fatigued and there is a consequent decrease in work tolerance. With the associated loss of muscle and soft tissue mass, there are frequent complaints of leg and foot cramps, which may or may not be associated with arteriosclerosis. Osteoarthritis, hyperostosis, senile osteoporosis, fixed deformities and marked limitation of motion are also noted and further contribute to the problems of ambulation.

The vascular system demonstrates trophic changes, coldness, pulse changes, and color variations. Arterial pathology can turn simple abrasions into gangrenous lesions.

Aging and chronic disease also produce many functional changes in the foot. Among these are a loss of sensation, complex gaits, reduced agility and tremors.

It is easy to demonstrate the needs of early diagnosis of foot pathology in order to achieve rehabilitation and maintenance of foot health at its maximum level. Three distinct relationships exist between podiatry and the chronic diseases in general:

1. Many general pathological conditions can be discovered during the course of a podiatric examination, interview or treatment program.

2. Persons with some chronic disease require podiatric care to control the pedal sequelae, as well as the pathologic changes of the feet associated with aging.

3. Many pedal conditions may become chronic. If untreated, they may result in a loss of ambulation and a furthering disability from other causes.

Although members of the health professions are primarily concerned with the prevention and treatment of disease, the elderly person's concerns are largely those of maintenance of the ability to see, hear, eat, and walk about. He or she needs to move about to see friends, pursue a hobby, make life more enjoyable, and lead a useful life as a member of his or her community.

The treatment of the foot is not usually surrounded by urgency and there is seldom, if ever, the matter of life or death. Complaints are usually those that take joy out of living. Many times, moreover, a patient will present himself to a podiatrist with no history of a physical examination during the past several years, and it is in these situations that podiatry can strengthen comprehensive medical care by appropriate referrals and consultations.

Systemic Disease of the Feet

A descriptive listing of diseases which manifest themselves in the foot would provide a prohibitively lengthy text. Rather it is the intention here to identify those that are common and to briefly describe their clinical manifestations and their primary complicating effects.

It should also be recognized that although many diseases present foot symptoms as initial complaints, the usual response in the elderly is toward the most overt abnormality with its varied complaints and symptoms. The individual is often faced with complications arising from various sources which make the podiatric care of the elderly anything but "routine," no matter how common is the condition. As an example of this, most old people develop thickened nails, the treatment of which is considered by many to be routine. However, elderly people also are prone to have some form of cardiovascular disease and thus, since this is common, its treatment might also be considered routine. But in fact, neither condition should be taken lightly and both must be managed to maintain the functional activity of the patient.

The initial consideration is one of patient management. The term can mean many things to many people, but in the aging or aged individual, it denotes a more serious problem than a behavorial and communication problem because of the real or potential dangers involved. It refers to the fact that elderly patients require care and treatment that is not routine, but has special understanding and special knowledge about unusual problems. Looking at the elderly patient, it is essential to see him or her as an individual with unusual sensitivity to drugs, a high susceptibility to infection, a lower threshold to physical and emotional stress, one or more serious systemic diseases and impairments, tissue that does not heal or repair readily, and a tendency to injure his lower extremities, thus reducing ambulation and producing a greater mortality risk.

Foot infection, with or without gangrene, is by far the major local complication in elderly people related to systemic disease entities and other factors. This situation often results in the necessity for amputation, and even in loss of life or the will to live. In general, one can identify the etiologic aspects of foot infection in the aged as those associated with:

a. Trauma, such as a cut, abrasion, or the result of crushing, blistering or pinching that breaks the intact skin.

b. Neglectful acts, such as poor hygiene, particularly poorfitting footwear resulting in a foot-to-shoe incompatibility and the production of blisters or raw areas. Impaired vision can turn "routine" foot care into hospitalization.

c. Changes due to the aging process in the skin, such as fissuring, dryness, hyperkeratoses and atrophy.

d. Metabolic changes associated with systemic diseases, such as those seen in diabetes and peripheral vascular disease.

e. Primary and secondary skin diseases.

f. The end result of some surgical procedures.

Osteoarthritis or degenerative joint disease can usually be identified in the elderly in its primary form or as secondary to trauma, inflammation or metabolic changes. The associated relationship between chronic trauma or strain and obesity is well reflected in the weight-bearing joints of the foot. Osteoporosis and postmenopausal syndromes also can be demonstrated often in the same individual. The primary findings in the foot include pain, stiffness, swelling, limitation of movement, and deformity. Clinically diagnostic associations may include plantar fasciitis, calcaneal erosions and/or spur formation with or without periostitis, osteoporosis, stress fractures, tendonitis, and tenosynovitis. Where osteochondritis was present at an earlier age, the end result is usually an osteoarthritic joint.

Existing deformities such as pes planus, pes cavus, and digital deformities such as hallux valgus, hallux rigidus and digiti flexus provide for increased pain, limitation of motion and a reduction in the ambulatory ability of the patient. The primary factor to consider is that osteoarthritis in the foot is usually secondary to repeated microtraumata and may be precipitated by inadequate foot care at earlier ages.

Traumatic Arthritis can be well demonstrated in the foot by the clinical entity of hallux rigidus and its earlier form, hallux limitus. Continued primary trauma to the first metatarsalphalangeal articulation provides the etiologic factor. In the elderly, the clinical feature resembles a monoarticular osteoarthritic joint. However, the bony bridging provides the need for patient mechanotherapy, as well as surgical consideration.

Neurotrophic Arthritis when identified in the elderly patient may be manifested by the atrophic changes seen in diabetes and by the hypertrophic changes seen in tabes. These represent the common diseases producing this form of joint disease.

Infective Arthritis can be present in the elderly patient as the end result of a single septic process of the joint and is associated sometimes with osteomyelitis. It may also be the residual of tuberculous, gonococcal or syphilitic joint disease.

Gouty Arthritis is the most common metabolic arthritic process. Clinically, the disease may provide symptoms in any joint of the foot and should always be suspected where intense pain is present without trauma. The primary manifestations in the elderly are related to chronic tophaceous gout and include chronic, painful, stiff joints, soft tissue tophi and a loss of bone substance.

Rheumatoid Arthritis in the elderly patient usually is presented as the end result of the disease with exacerbations of pain, joint swelling, stiffness, muscle wasting and deformity. Residuals in the foot include: painful pedal joints, hammer toes, forefoot spreading, progressive hallux valgus, calcaneal erosions, fasciitis, tendonitis, cystic and sesamoid erosions, fused digital articulations, phalangeal reabsorption, extensor tendon displacement with deformities, pedal rigidity and spurs.

Diabetes Mellitus is well known to be complicated by many pedal manifestations. Very often foot symptoms appearing in an individual who is not know to be a diabetic will lead to detection of the disease. The pedal manifestations are related to multiple systems and often are associated with a variety of symptoms and signs such as paresthesias, sensory impairment, motor weakness, reflex loss, neurotrophic arthropathy, muscle atrophy, absence of pedal pulses and the clinical findings of peripheral vascular impairment. Other common findings are dermatophytosis, chronic inflammation and infection, ulceration and terminal gangrene.

The dread neuroptrophic or diabetic ulcer is resistant to treatment and requires a multifaceted approach. The best treatment is prevention by the continual management of even minor foot problems. For example, ulcerations can be precipitated by continuous pressure causing local vascular impairment, penetration of tissue with trauma, and continued friction with thrusting and shearing of the plantar structures. The initial doctrine of prevention must be initiated by recognizing the liability and providing health education to the patient and his family. Management must include a multidiscipline approach.

Peripheral Vascular Insufficiency is present in the elderly patient in varying degrees. Overt indications of decreased arterial supply in the feet are muscle fatique, cramps, claudication, pain, coldness, pallor, paresthesias, burning, atrophy of soft tissues, trophic dermal changes such as dryness and loss of hair, absent pedal and related pulses, and decreased changes in the various functional tests, such as oscillometric readings, histamine wheal, etc. Many times, calcification can be demonstrated during the course of a podiatric X-ray examination. Often pain is mistaken for pathomechanical faults and blamed on "arch conditions" when the real problem is a lack of oxygenated blood to the part.

The terminal result of peripheral arterial occlusion, gangrene, can be well related to other factors such as smoking, occupation, exposure to cold, and cardiorenal pathology.

Edema, either related to cardiorenal disease or dependency, may be the first real sign of impending peripheral arterial complications.

Pedal ulcerations in the aged, associated with arterial insufficiency, are extremely slow-healing and are many times complicated by diabetes mellitus. The loss of collateral circulation and the possibility of occlusion from vasospasm provide an everpresent liability to the patient.

The peripheral circulation should have adequate support in patients leaving bed following a period of immobilization. Edema of the feet and ankles due to a combination of inactivity, dependency, immobilization, pain, muscle inactivity and venous insufficiency creates substantial complications. Venous insufficiency, with and without varicosities, leads to ulceration and stasis dermatitis. Topical infections must be considered as serious complications, and early treatment and management must be employed.

Paresis of the lower extremity, often the end result of a cerebral vascular accident, may result in foot drop, trophic changes, and new weight-bearing areas for which the individual cannot compensate. These changes can turn minor foot lesions into ulcerations.

Many diseases of the neurologic system can affect the foot and ambulation, such as cerebral palsy with gait abnormalities, post-cerebral vascular accidents, and multiple sclerosis. However, the primary problems are associated with incoordination of movements as a result of spasticity ataxia, peripheral neuropathies resulting in a loss of position sense, visual defects affecting ambulation, tremor and rigidity. Patients with mental illness or spastic cerebral palsy present foot defects and problems resulting from their inability to functionally adapt to gait and related system changes.

Conclusion

The attempt has been made to briefly outline the older person's special foot health needs, particularly those associated with systemic diseases. It should be noted that the podiatric management of many of these involves management of the pathomechanics related to disease. The prime concern should be the total patient and the utilization of all health professionals as a team if comprehensive care is to be achieved.

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Mini-Conferences have been recognized by the 1981 White House Conference on Aging and convened by organizations that wished to focus attention on special aging issues.

Recommendations of mini-conferences are not the recommendations of the official delegates to the Conference or the U.S. Department of Health and Human Services. They represent the views of the participants in the mini-conferences. They are being made available to the delegates as part of their background materials for the national conference.

The following Mini-Conference Reports have been published:

Recreation, Leisure and Physical Fitness
Aging and Alcoholism
Energy Equity and the Elderly
Public/Voluntary Collaboration: A Partnership in contributing to independent living for the aging
National Health Security
Concerns of Low-Income Elderly
Vision and Aging
Alzheimer's Disease
Arts, the Humanities and the Older Americans
Older Women
Life-Long Learning for Self-Sufficiency
The Urban Elderly
Rural Aging
Long-Term Care
Non/Services Approaches to Problems of the Aged
Spiritual and Ethical Value System Concerns
Transportation for the Aging
American Indian/Alaskan Native Elderly
Pacific/Asian Elderly "Pacific/Asians: The Widsom of Age"
Environment and Older Americans
Rights of the Institutionalized Elderly and the Role of the Volunteer
Veterans
Mental Health of Older Americans
Saving for Retirement
Hispanic Aging
Challenging Age Stereotypes in the Media
Oral Health Care Needs of the Elderly
Housing for the Elderly
Consumer Problems of Older Americans
Senior Centers
Elderly Hearing Impaired People
Black Aged
Legal Services for the Elderly
Simplifying Administrative Procedures and Regulations in Programs Affecting the Elderly
Intergenerational Cooperation and Exchange
Self-Help and Senior Advocacy
Euro-American Elderly
Inter-relationship of Government, Private Foundations, Corporate Grant-Makers and Unions
"The National Dialogue for the Business Sector"
Foot Health and Aging
Pacific Islanders Jurisdiction
Gerontological Nursing

the 1981
White House
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on
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Report of
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the
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Oral Health Care Needs

Introduction

The American Dental Association submits this report with the firm recommendation that the White House Conference on Aging give thoughtful consideration to the oral health needs of America's elderly population. Among the many disadvantages faced by this group that require immediate attention, poor oral health is significant. Fortunately, however, it is a problem for which solutions exist.

This report contains excerpts from papers presented November 19-20, 1980, at a conference on "The Oral Health Care Needs of the Elderly" sponsored by the American Dental Association in cooperation with the White House Conference on Aging. The purpose of the conference was to bring together nationally recognized authorities in the field of geriatrics and geriatric dental care to review and examine the current status of oral health care for the elderly and to prepare recommendations useful in changing national policy.

Unfortunately, limitations on the size of this report do not permit the reproduction of all papers presented at the conference. An attempt has been made, however, to present a representative sampling to clearly demonstrate the dimensions of the problem, and to suggest remedial efforts that should be undertaken.

Three general opinions repeatedly emerged at the conference: 1) additional research must be pursued to carefully document the effects of the aging process, 2) public and professional education must be enhanced, and 3) financial assistance programs must be expanded to provide both preventive and restorative treatment.

The American Dental Association has renewed its efforts in geriatric dentistry because it recognizes that poor oral health has a detrimental impact on one's overall health and, contrary to some widely held myths, that poor oral health is not an inevitable characteristic of aging. Optimum oral health can and should be enjoyed for a lifetime. To achieve this goal regular personal and professional care is required. Preventive dentistry can benefit all age groups, not simply the young.

The White House Conference on Aging is urged to sieze this opportunity to identify oral health care as a national health planning priority. The dental profession already has made this commitment and is anxious for national support from the White House Conference on Aging.

The following excerpts from the conference papers quickly summarize some of the major issues of oral health care for the elderly American. Copies of the complete set of papers presented at the American Dental Association's conference have been forwarded to the executive office of the White House Conference on Aging. Additional copies can be obtained by writing directly to the speakers whose names, addresses and titles of papers are provided in Appendix I.

I. Oral Health Needs of the Elderly*

A nationwide survey conducted by the National Center for Health Statistics in 1974 revealed that only 30.3% of all persons 65 and over had made one or more visits to the dentist within the past year (National Center for Health Statistics, 1975). Thus, in that year, approximately 70% of the elderly received no dental care. In fact, almost half of the elderly population (47.4%) had not been to the dentist in five or more years. Studies of the edentulous elderly have revealed that 72% had not sought dental care in five years or more (Gift, 1978; National Center for Health Statistics, 1974). These surveys have revealed that 55% of persons 65 to 74 years, and 40% of those over the age of 75 retain some or all of their natural teeth among the aged. However, the finding that almost half the population over 65 had either not seen a dentist for five years or had never visited a dentist suggests that a serious need exists for dental care for this segment of the population. This is compounded by the problem of increasing risk in old age of periodontal disease, tooth and bone loss, caries and specific oral disease associated with chronic diseases.

Two major problems are cited as creating barriers to proper rehabilitation and preventive care for older persons. These are the same problems all health services face in providing proper care for the elderly. First are the dental disease attitudes of older persons themselves. These attitudes are not adequately researched, but what findings there are suggest that older persons believe that poor oral health is a concomitant of aging and that nothing can be done. Chronic dental disease is accepted as a consequence of the aging process by the older person (Freidson & Feldman, 1958; Fishman & Bikofsky, 1972). Therefore, restorative and preventive dental care, even care for acute conditions, is not sought as much by the elderly as by younger persons. Even when free care is offered, many older persons do not take advantage of it (Fishman & Bikofsky, 1972). The second barrier is the attitude of dentists who feel, or are trained to believe, that older persons are poor candidates for dental rehabilitation and preventive care. The major cause of these attitudes is a lack of understanding about the nature and processes of human aging and their relationship to oral health. These attitudes are further exacerbated by the failure of dentists to communicate adequately with older persons and to understand their social and economic situations. A more detailed review of the literature in this area is presented below.

---

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Researchers on the health of older persons report a substantial amount of illness and impairments, many of these conditions representing chronic illness of long duration (Shanas, 1958; Riley & Foner, 1968). Chronic conditions, which include both impairments and chronic diseases, are far more prevalent among the old than the young (U.S. Survey, 1959). Well over three-quarters of the population 65 and older suffer from at least one chronic condition, and about half of them report two or more. This is significantly greater than the number found among the younger age categories (Spiegelman, 1970).

Nevertheless, when asked to evaluate their medical condition, many older persons assess their health quite positively. This may perhaps be because they have learned to accept certain disabilities and pains as inevitable or unimportant. Riley and Foner (1968) report that the older person's self-image tends to reflect the findings from the National Health Survey that only a small minority of older people aged 65 and over are too handicapped to carry on their major activity, despite widespread afflictions in old age. Among older persons, 43% rated their health as good or excellent. While this is lower than that for young people, it is surprising, considering the high rates of chronic disease and illness found among the aged.

For older persons, while there is a correlation between self-evaluation and medical evaluation, self-ratings tend to be more favorable (LaRue et al., 1978). Findings also indicate that older persons accept the effects of aging on external bodily features and appearance, and that they are less likely than younger age groups to be concerned about their appearance (Riley & Foner, 1968; Kahana, 1974).

Older persons are more likely than younger people to believe that ill-health and disability are to a degree unavoidable. In looking at all age groups, researchers report an increase by age in the proportion of persons agreeing with the statement: "A person has to expect a good deal of illness and some aches and pains, especially when he is old" (Riley & Foner, 1968). The elderly appear to view such conditions as an unavoidable corollary of aging; they do not consider themselves to be sick, but continue to lead relatively normal lives. This provides the basis for healthy coping and day-to-day functioning. At the same time, however, it acts as a barrier to seeking routine (i.e., preventive) medical and dental care until their health status has declined considerably.

Because perception of health status is an important determinant of one's beliefs and practices in the areas of medical and preventive care, the implications of this perception are significant. It is difficult to motivate such people to seek medical care for the many ailments that are not severely handicapping. It is even more difficult to attempt to make preventive service meaningful (DiCocco & Apple, 1958). This has been found among the elderly as well. Findings for persons over the age of 65 suggest that these persons are less interested in preventive care than younger persons, and that they have a greater tendency to believe they take the best possible care of their own health (U.S. Survey, 1960). In general, positive health care, or the prevention of disease, seems to decline with age. Persons over 60 or 65 are less inclined than younger people to report taking various steps to guard their health (Riley & Foner, 1968). Research on the reasons older persons with reported illness give for not seeing a doctor shows that they do not in general stress financial difficulties so much as the presumed unsuitability of medical treatment for many afflictions of old age (Shanas, 1968). In surveys specifically related to oral health, the majority say they have not sought dental care because they simply do not need it (Read, _et al_., 1976; Gift, 1978). Banting (1971) found low perceived need and high objective need for dental care among a sample of elderly poor. In our own research with low-income elderly vs. young enrollees of a free dental program (Miller & Kiyak, 1980), we found that elderly patients attribute less importance to dental care, perceive their dental health to be poorer, but perform fewer preventive dental care measures than do the young. This is consistent with previous investigations, and suggests that a sense of futility may be operating among the elderly. One statement that was made by several respondents was, "I reached the age of (60+), my dental condition was never good, so why should I expect it to get better now?". There seems to be an acceptance of poor oral health, supported by the psychological defense of minimizing the problem (i.e., oral health is not that important anyway; I may as well accept the situation and not seek out a solution).

II. Research on Oral Physiology and Aging*

Until recently the level of scientific activity on the process of aging was low. Only a relative handful of investigators, in most laboratory and clinical disciplines, addressed questions to this topic. With increasing public interest in geriatrics, the health sciences have become aware of the special needs and concerns of the aging individual. This has resulted in a marked rise in current investigative efforts. Certain disciplines have lagged behind in these activities. Dentistry (oral biology) is among them. In addressing the question of determining the oral health care needs of the elderly, we of the dental community must recognize that this task implies a simple, yet subtle, assumption. That assumption is that we are knowledgeable enough, about the oral physiological status of the aging and aged, to define real problem areas in the treatment of these individuals. This, I believe, is not a valid general assumption. To be sure we are not ignorant on the subject of geriatric dentistry, however, I would contend that we in fact know relatively little about the physiology of oral tissues across the adult life span.

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*Presented by Dr. Bruce Baum, Laboratory of Molecular Aging, Gerontology Research Center, National Institute on Aging, Baltimore City Hospital, Baltimore, Maryland 21224.

Although it is beyond the scope of this paper to exhaustively detail support for this assessment, it is necessary to provide some justification for the contention. To do this properly, as well as offer a perspective on the origin of my views, two definitions must be given; that of the terms aging and physiology. Aging will be defined here as representing a continuum of physiologic adaptation after traditional periods of maturation are reached. Thus, by this definition, aging is not simply equivalent to senescence. It is not an event which happens after we become 65, 70 or 85. From the time development is completed we are aging. Physiology is used here as encompassing a description of the "normal" range of function in a tissue. Since our physiologic control systems are adaptive, not static pre-set processes, we should not pre-judge what is "normal." An observed response difference between "healthy" groups (e.g. young and old) should not a priori imply pathology (a negative, detrimental effect). There is no reason to regard that which is normal for a "healthy" 25 year old to be normal for a "healthy" 75 year old.

Given this perspective, an evaluation, albeit limited, of what might be termed current knowledge, is in order.

Descriptions of the "Aging" Oral Cavity

An examination of 16 textbooks and review articles (spanning the last 20 years) whose purpose, at least in part, was to provide a description of the oral physiologic status of the aged individual, has resulted in finding a common series of alterations usually presented. Many of these alterations have come to be considered as concomitants of growing old and all reflect negative changes.

Are such generalizations valid? Surprisingly except for loss of teeth, and to a much lesser extent the prevalence of cervical caries and the structural alterations in dental tissues, there is little reliable epidemiologic data available to judge the meaning of significance of these purported age-related changes. To adequately evaluate individual findings, it is necessary to go beyond the texts and reviews, to the actual reports upon which these generalizations are based and assess their methods, data and conclusions.

The close examination of many earlier reports erodes the support of most of the suggested generalized changes in oral tissues of the aged. In many instances (e.g. salivary function studies, oral mucosal changes, sensory studies) the actual data available does not lend itself readily to drawing any uniform conclusions. Further, in most studies, one can recognize many design or methodological concerns which would prevent utilization of the data for making broad population descriptions. Importantly, it must be recognized that many often referenced aging/oral health studies are 20-40 years old. Thus, we presently benefit from the methodologic improvements and conceptual advances made since the original studies were reported. This advantage, however, comes with the scientific obligation to build on past studies, not just accept their published findings as ultimate facts.

All of the concerns are important in distinguishing the normal physiological status during aging (i.e. what is due to growing old) from circumstances which result when pathology and/or pharmacologic therapy are superimposed on the aging individual. Especially noteworthy is the lack of careful medical and dental characterization of subjects studied. This substantially limits the scope of conclusions which can be made. Thus, the question of determining what are the oral health care needs of the elderly really has two parts: 1) Are there fundamental alterations in the physiology of the aging oral cavity which require professional concern, observation and/or treatment? and 2) Since there is a high rate of disease present among older individuals, are there special problems that systemic pathology (and its therapeutic treatment) might foster on the oral environment?

Based on my reading of available literature, I would conclude that in many instances the above two points have not been separately addressed. What has resulted is an unclear and possibly confusing picture of oral physiology/oral health during aging. In order to approach this problem directly, the National Institute on Aging (NIA) in July 1978 began an oral physiology program at its Gerontology Research Center.

III. Prosthodontic Needs of the Elderly Patient*

Because of tooth loss, the elderly patient is confronted with possible changes in personal concept of body image, facial appearance, masticatory efficiency, speech performance, and as a result of all of these, perhaps, social acceptance. Healthy, emotionally and socially adaptive patients will generally have little problem adjusting to the change from natural to artificial dentition if properly prepared by the dentist to understand prosthesis limitations. Other patients compromised by chronic illness, oro-facial disability, or acute disease will likely respond with more anxiety to the prospect of dentures. Some may feel compelled to transfer the blame for their undesirable dental condition to family members, friends, or not uncommonly, their dentist. Patient attitudes influence prosthesis acceptance and must be ascertained and receive treatment considerations just as the morphological defect.

It has been said that the success or failure of an oral prosthesis depends as often on the health and tolerance of the oral tissues as upon the technical skills of the prosthodontist. The health of denture supporting tissues is affected by nutrition and the elderly patient without adequate dentition is commonly lured to a diet frequently lacking in some of the essential nutrients. The quantity and quality of residual ridge bone are pertinent to denture success. Normally slowly progressing with age, ridge loss by resorption is enhanced and hastened by nutritional deficiency and individual disposition. Osteoporosis is not uncommon among the elderly, particularly post-menopausal women in whom the estrogenic blood level is abnormally low. It occurs when the internal bony sources of calcium are tapped to compensate for a lack of calcium intake, failure in absorption, or deficient transport and may be severe when all of these deficiency states occur in combination. Whether for natural or artificial teeth, inadequate bony support is a principle cause for prosthesis failure in elderly patients.

Accompanying untoward bony responses in the oral aging process, are similar soft tissue changes. Manifestations of mucosal atrophy include thinning of the epithelium of mucous membranes, loss of resilience, decreased blood supply, low tolerance, and loss of regeneration potential. Salivary glands undergo regressive changes resulting in reduced salivary flow and subsequent dry mouth. This condition may be compounded by body metabolic changes, disease entities, and medications. Without saliva, natural teeth are not self-cleansed; mastication and deglutition are compromised; denture retention becomes difficult; taste sensation is diminished; and inadequate mucosal lubrication encourages irritation and inflammation beneath movable denture bases. Body water balance is essential in preventing tissue dehydration. A negative water balance not only affects salivary secretion, but limits the effectiveness of muscle and joint function in the stomatognathic system.

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*Presented by Dr. William Laney, Department of Dentistry, Mayo Clinic, Rochester, Minnesota 55901.

Whether or not elderly patients have other specific nutritional needs varies from individual to individual. When these are identified, they generally can be attributed to a variety of medical, psychologic, social and economic factors. Effective nutrition for today's older generation requires attention to the particular needs of each individual.

IV. Dental Education and Geriatrics*

Dental curricula in most dental schools contains little substantive material that is directly related to the aged patient. Only within the past few years does one find information taught dental students about aging anatomical changes - not just head and neck - but total skeletal and neuro-muscular changes, altered physiologic function - chronic pathology of the principle systems - important pharmacologic influences that affect individuals - complex nutritional problems of availability as well as metabolism - psychosocial changes in behavior - attitude, interpersonal relationships as well as the devestating effects of socio-economic forces that markedly influence the dentist's ability to provide rational oral health care.

There is some geriatric material sandwiched into courses in prosthesis and periodontics. However, nothing that is broad in concepts or ever definitive.

If dental schools are deficient in their undergraduate curricula - one is even more aware of the woeful lack of geriatrics presented in post-graduate courses or in the programs of state - local and even national meetings not only for the gerodontists but specialty groups.

Dr. Saul Kamen, in a paper on Skills Training in Geriatric Dentistry that he presented at the Geriatric Symposium at the ADA meeting in New Orleans in October, 1980, quoted Dr. Julius B. Richmond, surgeon general of the U.S. Public Health Service, in a significant speech before the Annual Session of the American Association of Dental Schools in Washington, D.C., in March, 1978, who stated "we cannot be satisfied with our efforts as long as 50 percent of the elderly are without natural teeth and 25 percent of all those over age 35 have lost all of theirs!!......The nation's dental schools have a central and critical part to play in meeting the need for equity in our health care system and for access to care of the highest possible quality....dental health and the provision of effective dental health care depend on an expanding body of scientific knowledge."

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*Presented by Dr. Sidney Epstein, University of California, 490 Post Street, Suite 1450, San Francisco, California 94102.

Dr. Kamen made other succinct statements that I quote: "Several factors distinguish dental care for the elderly from that for the young and middle aged,

1) The special oral problems of the aged require a distinct body of knowledge and skills geared to the biological, physiological, pathological, and psychological effects of aging on the oral apparatus. In this respect, it is clear that dental schools have provided inadequate training in gerodontics, both to predoctoral and postdoctoral students. Basic science courses in the undergraduate curriculum rarely consider the individual past 45 or 50 years of age, while clinical instruction emphasizes dental treatment for relatively healthy, younger patients. The student, obsessed with meeting the required number of procedures, focuses on the dentition rather than on the patient's total functioning. The gerodontist, on the other hand, must assess not only the presence of disease but the patient's total physical and mental deficiencies as well as his socio-economic environment in order to establish realistic goals of treatment.

2) A significant portion of geriatric dental care is delivered to physically and psychologically compromised patients. The extension of the median survival age and life-expectancy carries with it an inevitable increase in the number of such patients who present a formidable challenge to dental management. It has been estimated that the average general practice today comprises 25% of such patients. Consider the fact that 86% of the over 65 population have at least one major chronic disorder, 5 to 10% of the non-institutionalized elderly have some degree of cerebral dysfunction, and 50% of the residents of nursing homes have acute or chronic organic brain syndromes. Dental practitioners, by and large, are ill-trained to cope with the diagnosis and treatment planning of such patients.

3) Current academic programs in geriatric care are substantially confined to the dental school clinic, and are usually vested in departments of removable prosthodontics, with very little input from behavioral and gerontological disciplines. Beyond the occasional consultative function, there is little opportunity for participation by physicians, social workers, pharmacists or other

helping professionals in the dental care plan. Training in geriatric dentistry requires significant exposure to off-site skilled nursing facilities where the interdisciplinary environment enhances appropriate attitudinal, cognitive, and psychomotor skills in the aspiring practitioner."

We are now developing at UCSF a detailed interdisciplinary program that will have a curriculum for establishing team concepts. The objectives are to utilize the knowledge and skills of physicians, dentists, nurses, pharmacists and social workers to provide assessment, evaluation and resolution of the elderly patient's needs.

4) "Academic dental centers suffer from a lack of faculty trained in geriatric dentistry. The National Institute on Aging has within the past year announced the first concerted effort to promote academic careers in geriatric dentistry through the institution of academic awards. Nevertheless, there is probably less than a score of academicians in the dental schools of this country who have had advanced training in gerodontics, compared with hundreds in other disciplines of dentistry.

5) There is an inadequate literature in geriatric dentistry, reflecting in large measure the lack of scholarly pursuit and research in this area. In the past decade one can count on the fingers of one hand the number of major textbooks in gerodontics which have appeared nationally or internationally, while to this author's knowledge there is only one dentist in the entire country today engaged in full-time research specifically in aging.

In the light of shortfalls in dental training which we have cited, it is a small wonder that we are facing the decade of the 80's with grossly inadequate geriatric manpower for primary dental care. It has been estimated that by the year 1990 the U.S. will need to train about 8,000 physicians to deliver adequate medical care to people aged 75 and older. (Kane, R., Solomon, D., Beck, J., Keeler, E. and Kane, R.: The future need for geriatric manpower in the U.S.; New England Journal of Medicine, June 1980, Vol. 302, No. 24, pp. 1327-32). Extrapolating the number of needed dentists to this figure, we may estimate by the end of this century it will require approximately 4,000 dental practitioners with gerodontic skills to supply necessary oral health services for this population, assuming that barriers to such care will be lowered. It is obvious that much of this burden will have to be delegated to non-dental clinicians, such as dental hygienists." (Saul Kamen: Unpublished paper presented at 121st American Dental Association Annual Seminar New Orleans, October, 1980, 11-15).

V. Role of Dental Education*

Dental schools have been charged with the responsibility for preparing graduates to improve the dental health of the population. Therefore, it is necessary that curricula be responsive to the needs of the public. The rapid growth of the elderly population, their high level of unmet dental needs and their limited access to dental care are all issues that need to be addressed by the educational enterprise. As preventive measures become more effective and the population more aware of the actions that result in the preservation of teeth there will be more people in the older age groups who will have natural teeth after they reach 65 years of age.

As the edentulous rate among the elderly drops more emphasis will have to be placed on preparing dental graduates to provide preventive and restorative care for their aged patients. Success in this area will be predicated on developing more curriculum materials in the special needs of the elderly as they relate to the dentist's ability to provide appropriate services. Graduates will have to be prepared to work with elderly people who have caries, periodontal disease, and missing teeth and whose dentition can be preserved from further tooth loss. Innovative approaches will surely have to be implemented because the elderly patient will also be confronted with limited resources and many of the usual biological, clinical and behavioral problems associated with aging.

A recent study by Ettinger demonstrated the paucity of curriculum content in geriatric dentistry. His findings prompted others including Gilmore to bring the situation to the attention of curriculum planners. Gilmore was responsible for organizing a committee to prepare guidelines in teaching geriatric dentistry that could be presented at the 1981 session of the American Association of Dental Schools. The recommendations of this committee can be summarized as follows:

(1) Curriculum content should emphasize an integration of several disciplines due to the broad range of variables associated with meeting the dental needs of the aged.

(2) Attempts should be made to identify one or more faculty persons who will assume responsibility for coordinating the curriculum materials.

(3) Essential curriculum content should focus on a combination of didactic course work, experiential learning in a variety of settings, and patient care activities.

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*Presented by Dr. Ames Tryon, Department of Community and Oral Health, School of Dentistry, University of Mississippi, 2500 North Jackson, Mississippi 39216.

(4) Patient care for the aged person should be integrated into the general clinic routine of a dental school rather than being physically separated.

VI. A Model Dental School Program on Aging*

The University of Iowa's College of Dentistry has developed an interdisciplinary undergraduate dental curriculum focusing on the special physical and psychosocial needs of the aging patient and methods to meet these needs. The curriculum is collegiate and occurs over four years of instruction, utilizing didactic and experiential approaches to learning. For senior dental students it culminates with treatment of nursing home patients using portable dental equipment. An interdisciplinary committee oversees the curriculum and proposes changes as needed.

Instruction brings together information and resource persons from medicine, pharmacy, nursing, social work, nutrition, and others, to discuss problems including, but not limited to, hearing; sight; mental acuity; disabilities that restrict mobility; dental changes; socioeconomic changes; changes in income and family situations which restrict access to care; nutrition; the presence of multiple diseases; drug therapies; special needs for health maintenance; and other psychosocial problems. Specifically, one new course and five segments of other courses have been developed to increase required clock hours of instruction from 0 to 54. Focus of instruction is upon the special needs of the elderly in the primary health care system and proposed methods to deal with these needs.

Goals of instruction include the following:

1. To impact upon the prevailing stereotypic thinking about the elderly through:
   a. Identifying myths and stereotypes associated with aging.
   b. Describing the social and cultural aspects of aging.
   c. Emphasizing empathetic approaches to teaching about the elderly.
2. To describe the biological aspects of aging, as well as the psychological processes involved in adjustment to aging.
3. To present the epidemiologic and clinical aspects of aging including:

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*Presented by Dr. Ronald Ettinger, University of Iowa, College of Dentistry, Dental Building, Iowa City, Iowa 52242.

    a. Need and demand for clinical service.
    b. Treatment planning.
    c. Scheduling.
    d. Office design.
    e. Patient management techniques.

4. To identify resources available to the elderly including:
    a. Aid in financing care.
    b. Social services.
    c. Day care centers.
    d. Community centers.
    e. Religious institutions.
    f. Health services.

5. To provide clinical experiences with institutionalized and non-ambulatory elderly including:
    a. Nursing homes.
    b. Hospitals.
    c. Home care programs.

It was considered important to begin the program in the freshman year. Studies on medical and dental students have consistently demonstrated that students' attitudes become hardened and more cynical as they progress through school, and that junior dental students have an even more negative attitude toward the elderly than freshmen. Thus, it seems necessary from the first contact with students to attempt to modify their stereotypic thinking and their attitudes. The process of education must begin by improving their knowledge about the aged and aging. Knowledge about the individual difference in the biology of the aging may help to change misconceptions and attitudes. It must show them how our modern, mobile, technological society has often isolated older persons, deprived them of a role and identity in society, and created a fear of aging which results in stereotypic thinking -- even among the elderly themselves.

VII. Dental Care in Nursing Homes*

What is the status of dental programs in the nursing homes of this country? Despite the fact that it has been estimated that 18 percent, or approximately one out of every five nursing homes in the U.S., provides dental services (and one wonders as to the comprehensiveness of such services), there has been a noticeable improvement in this regard, both in quality and quantity.

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*Presented by Dr. Saul Kamen, Jewish Institute for Geriatric Care, 271-11 76th Avenue, New Hyde Park, New York 11040.

In the course of delivering lectures and seminars throughout the country in the past three years, I have been privileged to meet hundreds of dedicated nursing home dentists, of whom our profession should be proud.

It must be remembered that in the early 1970's, with a few notable exceptions dental programs in long-term care facilities were almost non-existent. The major impetus to the improvement of dental care was derived in 1974 from the Conditions of Participation for Skilled Nursing and Intermediate Care Facilities in Medicare and Medicaid programs, as promulgated by the Health Care Financing Administration, then the U.S. Department of Health and Human Services. This document set forth minimal standards of dental care which included the appointment of a dental advisor consultant responsible for patient care; in-service education; policies for oral hygiene, emergency care if necessary, and referral of patients who require regular care to dentists. The nursing home operator was required to provide transportation when necessary to a dentist's office or other facility for necessary dental treatment. Despite this forward movement, oral neglect was cited among the litany of abuses of nursing homes by the U.S. Special Subcommittee on Aging in its investigations in the mid 70's. Perhaps in response to these disclosures, and as a consequence of an intensive educational program launched in 1976, jointly by the American Dental Association and the American Society for Geriatric Dentistry, and funded by the U.S. Public Health Service, there has been a noticeable elevation of oral health programs, and I am personally aware of many new dental services in long-term care facilities. What is needed is stricter enforcement of the existing rules and regulations, and this requires the combined efforts of government agencies, a vigilant profession, and the elderly themselves as advocates for better dental care.

Looking ahead to the decade of the 80's those who are concerned with dental care for the institutionalized elderly cannot complacently accept the current status of dental services in nursing homes. In many ways, the failure of this industry to comply with Medicare and Medicaid regulations requiring such services, for they are observed more in the breach than in the performance, reflects societal attitudes towards the elderly. Without intending invidious comparisons, it is a sad fact that the institutionalized mentally disadvantaged in this country are receiving dental services which are denied to the institutionalized elderly.

In the state of Alabama in 1972, for example, Federal Judge Johnson, in the case of Wyatt vs. Stickney, ruled that the residents of the Partlow State Institute for the Mentally Retarded should be provided with dental services in the ratio of one dentist for every 200 in population. As a matter of fact, most Intermediate Care Facilities in the U.S. now have on-site dental facilities with paid dental staff. I believe the time is ripe for those of us who are committed to decent care for the elderly to insist that a long-term care facility with a population of 250 or more residents should have an appropriately equipped on-site dental facility to provide for oral care as one of the essential services for total health and rehabilitation.

The existence of poor oral health in a nursing home is an indication of poor quality of care and should be cited as a deficiency in on-going review processes. Poor oral health places the nursing home resident at higher medical risk, diminishes the quality of remaining life, and unless ameliorated may add significantly to the cost of institutionalization. In terms of the economics of nursing home care, this argument for good dental care is one to which bureaucrats may be particularly responsive.

If comprehensive dental care is to be provided to long-term facilities, we shall have to train more dental manpower to provide such services and certainly utilize our dental auxiliaries to better advantage. As a matter of fact, dental hygienists are absolutely essential to the care of the institutionalized elderly, and I would hope that in the decade of the 80's they may find more career opportunities in this field. For this reason, we have recommended that to the definitions of key professions in skilled nursing facilities there be added the following: "Where state law permits, the term dentist includes a dentist directed team of dental hygienists and dental assistants. Direction need not be on-site, but the dentist is responsible for supervision." We have also urged that it is critical that the nursing home include at least one qualified dentist in a salaried position either as attending staff or in an advisory capacity.

Should nursing home dental programs be integrated in predoctoral and postgraduate dental education? I believe the decade of the 80's will give a positive response to this question, precisely because a significant exposure to the problems of the institutionalized elderly enhances the ability of the practicing dentist to treat the ambulatory geriatric patient with competence and confidence. Medical education in geriatrics in the past decade has taken giant steps in this direction, and most medical schools have incorporated basic gerontological sciences in their undergraduate curriculum. Residency programs in geriatric medicine in skilled nursing homes have multiplied rapidly in the last few years. Until 1977, for example, there was only one such residency in geriatric medicine in the entire country at the Jewish Institute for Geriatric Care, in which I serve. This year there are approximately 30 such programs, and the competition to secure residents of high caliber has increased enormously. To my knowledge, there are at present only two accredited residency programs in geriatric dentistry in the U.S., and I certainly look forward to a significant increase in such opportunities in the next decade. There are, however, many dental services in long-term care facilities which can offer educational experiences to properly prepared dental students and dental hygiene students. I say properly prepared advisedly because I believe it can be a frustrating experience to subject an undergraduate student to a nursing home with debilitated, demented, and terminal patients without orientation and a preliminary or basic core curriculum. Having enjoyed an affiliation of several years with several dental schools, and with the School of Dental Hygiene of the State University of New York at Farmingdale, New York, I can assure the participants in this conference that our young professional aspirants respond enthusiastically and positively to a meaningful experience with our patients. I suppose it is like extolling motherhood to ask this conference to endorse the concept of off-site rotations of dental and dental hygiene students to long-term care facilities, but I shall nevertheless recommend this to our workshop this afternoon for concrete action.

VIII. Financing Dental Care for the Elderly*

Because dental services are not covered under Medicare and are an optional benefit under Medicaid, of the $1.4 billion spent on dental treatment of the elderly in 1978, only 3% was paid by public funds.

An American Dental Association 1979 survey determined that only 37 of 50 Medicaid programs included dental care for adults and, of these, six provided only emergency care.

The first step to assuring that the more than three million elderly persons below the national poverty level have an opportunity to receive dental care is to amend Title XIX of the Social Security Act to change dental care from an optional service to a basic, mandated service. The American Dental Association has been seeking such an amendment since the inauguration of the program.

In the private sector dental insurance over the past decade has proved itself to be arguably the most important instrument to improve access to dental care. But, our elderly citizens today remain the victims of age discrimination in employment, arbitrary retirement practices and biases against hiring older people for available jobs.

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*Presented by Dr. Roger Hehn, chairman, American Dental Association Council on Dental Care Programs, 2047 Park Street, Jacksonville, Florida 32204.

At the same time, dental benefit plans are largely available only to groups of employed people. So the elderly, a population of severely limited income, is denied the benefits of the one instrument that could help dismantle the economic barrier to dental care for them.

Now, what has the American Dental Association been doing about this? For the past five years, the Council on Dental Care Programs, of which I am Chairman, has been urging insurance firms to market plans to elderly persons, retirement communities, organizations of retired persons and the like. Our efforts to date have largely been unsuccessful. One of the reasons, perhaps, is that we have found in our discussions with national organizations of retired persons, a belief that the interest on the part of members in obtaining dental insurance is not strong. A similar attitude was expressed two years ago when, at our urging, a national carrier organization surveyed its member plans to determine if any would be willing to provide dental benefits in their Medicare supplement packages, at least on an experimental basis. At that time, there were no takers. Our Council meets with perspective purchasers of dental benefit plans on a regular basis. These are mainly national employers. We urge them to include their retired employees in their dental programs. Here, we have had some success. The auto industry, for example, now provides its dental benefits into retirement. The AT&T - Telecommunications dental program extends into retirement as well. Last year, Eastman Kodak provided dental benefits to its employees for the first time and made the decision from the outset to include retirees.

There is some hope for improvement in dental coverage in Medicare supplement packages, too. Earlier this year we were informed that Blue Cross/Blue Shield in Santa Barbara, California, had decided to include comprehensive dental benefits in its Medicare supplement package, an HMO plan called UltraCare. This is being done on an experimental basis but it is not a pilot program in the usual sense. There is no plan to terminate this coverage after a given period of time. We are told it is experimental only in the sense that Blue Cross and Blue Shield Associations will review the experience of the Santa Barbara plan to determine the feasibility of including similar programs and their other plans. So there are some encouraging signs. At the same time, the Council on Dental Health and Health Planning has been surveying constituent dental societies throughout the country and has developed a document describing programs to provide dental care to the elderly at reduced fees.

But none of these activities is the real answer. The answer will come only when dental health benefits are included under Part B of Medicare. It is the Association's intention to mount a campaign to persuade the next administration and the next Congress to amend Title XVIII of the Social Security Act to include dental benefits under Medicare, Part B. It should be emphasized that this is the focal effort of the plan to improve the accessibility of dental care for elderly persons.

We intend to recruit through our state dental societies, groups and individuals who share this interest: chapters of the American Association of Retired Persons - Retired Teachers Association, civic councils on aging, state senior citizens councils, as well as the many involved faculties of dental schools and socially active union and industrial leaders. We will seek to collect data related to the cost of medical and hospital services to treat conditions of the elderly, caused or aggravated by ineffective mastication. We will no longer accept the argument that at $1 billion or $1.5 billion annually, dental care is too expensive to include under Medicare. That position is hopelessly myoptic. The savings to Medicare alone in health care services no longer needed because people at last are able to eat properly and digest their food has never been calculated. And, finally, with the help of our allies, we will send a message to the Congress and to the President, that the time for this much needed amendment has come and the human needs of the elderly can no longer be deferred. Nelson Cruikshank, former president of the National Council of Senior Citizens, said, "We know that a nation as rich as ours, with gross national product amounting to more than a trillion dollars a year, can afford to rescue the young and old from the miserable life of the forgotten poor."

One small way that we in dentistry can help to achieve Mr. Cruikshank's vision is through this change in our basic health care policy. We must do this, not merely for our elderly people of today, but for ourselves. David Hackett Fischer, the author of Growing Old in America, said, "We are not merely witnesses to our history but its agents and even its authors. What happens in the future is determined by what we wish to happen."

* * *

Conclusion

The foregoing has brought to the surface critical issues which require priority attention by the nation. If we are to make significant progress toward improved oral health for America's older population the following initiatives are imperative:

1) Research on the aging process both in general and in particular as related to oral health, must be continued and expanded;

2) Oral health education directed toward older Americans and professional education concerning geriatric dentistry must be fostered;

3) Financial assistance programs for those elderly in need must be extended to include preventive and restorative oral health care services, and

4) Access to dental care for older Americans must be provided by removing physical barriers and by bringing dental care to the homebound and institutionalized.

The American Dental Association is proud to have participated in the White House Conference on Aging and looks forward, hopefully, to a brighter, healthier future for all older Americans.

# # #

Appendix I

Conference on the Oral Health Care Needs of the Elderly
American Dental Association
November 19-20, 1980

Speakers

"Research on Oral Physiology and Aging"
Dr. Bruce Baum
Laboratory of Molecular Aging
Gerontology Research Center
National Institute on Aging
Baltimore City Hospital
Baltimore, MD 21224

"Dental Education and Geriatrics"
Dr. Sidney Epstein
University of California
490 Post Street
Suite 1450
San Francisco, CA 94102

"A Model Dental School Program on Aging"
Dr. Ronald Ettinger
University of Iowa
College of Dentistry
Dental Building
Iowa City, IA 52242

"Financing Dental Care for the Elderly"
Dr. Roger Hehn, Chairman
ADA Council on Dental Care Programs
211 East Chicago Avenue
Chicago, IL 60611

"Dental Care in Nursing Homes"
Dr. Saul Kamen
Jewish Institute for Geriatric Care
271-11 76th Avenue
New Hyde Park, NY 11040

"Psychosocial Factors in Dental Needs of the Elderly"
Dr. Asuman Kiyak
University of Washington
School of Dentistry
Dept. of Community Dentistry
SM-35
Seattle, WA 98195

"Prosthodontic Needs of the Elderly Patient"
Dr. William Laney
Dept. of Dentistry
Mayo Clinic
Rochester, MN 55901

"Summary of NFDH Dental Delivery System for Homebound and Nursing Home Population"
Mr. Fred Leviton
Assistant Director for Program Development
National Foundation of Dentistry for the Handicapped
1726 Champa, Suite 422
Denver, CO 80202

"Preventive Dentistry for the Elderly"
Ms. Sheryl Short
Dallas City Dental Health Program
3626 North Hall, Suite 720
Dallas, TX 75219

"The Aging Process and Nutrition: Conception to Senescence"
Dr. Harold Slavkin
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Mini-Conferences have been recognized by the 1981 White House Conference on Aging and convened by organizations that wished to focus attention on special aging issues.

Recommendations of mini-conferences are not the recommendations of the official delegates to the Conference or the U.S. Department of Health and Human Services. They represent the views of the participants in the mini-conferences. They are being made available to the delegates as part of their background materials for the national conference.

The following Mini-Conference Reports have been published:

Recreation, Leisure and Physical Fitness
Aging and Alcoholism
Energy Equity and the Elderly
Public/Voluntary Collaboration: A Partnership in contributing to independent living for the aging
National Health Security
Concerns of Low-Income Elderly
Vision and Aging
Alzheimer's Disease
Arts, the Humanities and the Older Americans
Older Women
Life-Long Learning for Self-Sufficiency
The Urban Elderly
Rural Aging
Long-Term Care
Non/Services Approaches to Problems of the Aged
Spiritual and Ethical Value System Concerns
Transportation for the Aging
American Indian/Alaskan Native Elderly
Pacific/Asian Elderly "Pacific/Asians: The Widsom of Age"
Environment and Older Americans
Rights of the Institutionalized Elderly and the Role of the Volunteer
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Mental Health of Older Americans
Saving for Retirement
Hispanic Aging
Challenging Age Stereotypes in the Media
Oral Health Care Needs of the Elderly
Housing for the Elderly
Consumer Problems of Older Americans
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Inter-relationship of Government, Private Foundations, Corporate Grant-Makers and Unions
"The National Dialogue for the Business Sector"
Foot Health and Aging
Pacific Islanders Jurisdiction
Gerontological Nursing

the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on
Concerns of Low-Income Elderly

MCR-7

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

LOW INCOME ELDERLY

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No longer must American aged live in hunger, suffer from lack of health care, exist in delapidated housing, and remain hidden from the mainstream of American life. While we must improve the life for all the aged, our top priority must go to those who suffer most. America must address itself first to the needs of the elderly poor.

- from the 1971 WHCoA
  Report to the Delegates

Do it now! I won't be around in ten years for the next conference.

- Ms. Mary Powell, a 1971
  delegate to the WHCoA
  quoted at the Conference

Quite a lot's been done, but not a whole lot for us.

- Ms. Mary Powell, quoted
  February 12, 1981.

BACKGROUND OF THE MINI-CONFERENCE

Ms. Powell is around ten years later and unfortunately so are many of the problems and concerns she brought with her as a low income delegate to the 1971 White House Conference on Aging. In some ways the elderly of all income levels are better off than they were ten years ago; in other ways, due to the ravages of inflation and the effects of a generally harsh economic climate in the nation over the last decade, the elderly, especially the elderly poor, are less well off. This segment of the American population, generally under-represented on or absent from decision-making bodies, private and public, has taken a small step in 1981 towards having itself heard. The opportunity was the 1981 White House Conference on Aging and the vehicle was a pair of Mini-Conferences on Concerns of Low Income Elderly.

The 1981 White House Conference on Aging (WHCoA) marks the incorporation of the mini-conference format into the overall structure of the conference. This component has been conceived as a forum for the expression of views by special interest groups within the elderly community, and, to date some 35 mini-conferences have been convened under the sponsorship of groups as diverse as the Gray Panthers and the American Podiatry Association.

The National Community Action Agency Executive Directors Association is a national membership organization comprised of the directors of the nation's network of Community Action Agencies. These are the men and women who are at the forefront of the nation's ever-present effort towards eliminating poverty. Through their organizations, the members of NCAAEDA represent some 20 million low income Americans. Believing that the problems of elderly poor Americans deserved special and separate attention, NCAAEDA sought and received recognition from the White House Conference on Aging to sponsor a Mini-Conference on the Concerns of Low Income Elderly.

The Conferences--In January, 1981, NCAAEDA convened a White House Conference on Aging, Mini-Conference on the Concerns of Low Income Elderly. Two meetings, one in Washington, D.C. covering the states in Federal Regions I-V and one in Kansas City covering the states in Federal Regions VI-X, were held to develop recommendations on ten issues of importance to the elderly poor: Retirement Income, Health Services, Long-term Care, Nutrition, Energy, Transportation, Employment, Elderly and the Work Ethic, Housing, and Urban and Rural Service Delivery. NCAAEDA planned and coordinated the eastern conference. The western conference was planned and coordinated by Region VII Community Services Administration and West Central Missouri Rural Development Corporation.

Approximately 350 low income elderly delegates attended the two convention-style conferences, defining issues and establishing priorities during small issue group sessions. Each conference closed with a resolution adoption session in which delegates formally amended, adopted or rejected the recommendations brought forward by each group. Throughout the conferences, 230 non-voting staff participants from local, state and national organizations assisted the delegates in this process.

The elderly poor have directly experienced the problems associated with age and poverty and richly deserved an opportunity to express their concerns within the WHCoA. The following report is testimony to their hard work and dedication.

ELDERLY POOR AMERICANS--STATISTICAL OVERVIEW

In 1977, at least 3.2 million persons 65 years or older lived on incomes which placed them below the poverty level. This figure represents 14.1% of the total elderly population (currently estimated to number some 24.1 million Americans) and means that nearly one out of every seven persons 65 or over lives in poverty.

Certainly, a more recent population figure for the elderly poor would be preferable. However, it is doubtful that any projected figure, regardless of recency, would meet with complete agreement concerning its accuracy. Based on the diversity of assumptions which have been used to determine poverty levels, the number of elderly who are classified as poor can vary from as few as 1.5 million (Congressional Budget Office, 1977) to as many as 8.7 million (U.S. House of Representatives Select Committee on Aging, 1978).

The rate of poverty among elderly Americans is greater than their percentage of the total population. Although persons 65 years or older represent 10.0% of the total population, the elderly constitute 13.8% of America's poor. This greater representation of the elderly among the poor is even more pronounced when the poverty index is raised 25% to 50%. The elderly represent 15.8% of all Americans whose incomes fall below 125% of the poverty guideline and 16.4% of all Americans whose incomes fall below 150% of the guideline. Thus, it is evident that the elderly are not only over-represented among the poorest in America, they also comprise disproportionately high numbers of the so-called "near" poor unfortunately, for the millions of elderly who are numbered among the "marginally poor," it is not likely that this minor increase in income provides a substantial improvement in living conditions.

Older blacks (36%) and Hispanic Americans (22%) are more likely to be poor than elderly whites (12%). In addition, elderly women (16.7%) are more likely to be poor than elderly men (10%). In 1975, the median income for a man over 65 was $4,959, but for an elderly woman it was only $2,642.

Of the elderly living in rural areas, 10% are poor. In contrast 11% of the elderly in metropolitan areas have incomes below the poverty level.

About two-thirds or 2 million of the elderly poor were persons living alone or with non-relatives. The large percentage of elderly poor (66 2/3%) living alone or with non-relatives contrasts sharply with the non-poor elderly, most of whom live in family settings (4 out of every 5 elderly men; 3 out of every 5 elderly women).

RESOLUTION TOPIC--RETIREMENT INCOME

Very few elderly Americans, regardless of income level, depend on wages as their major or sole source of income. In fact, out of a total of 21,662,000 elderly in 1976, only 369,000 depended on earnings as their sole source of support. Over 75% of all persons 65 years or older receive no wages or salaries and depend on Social Security, Supplement Security Income (SSI), veterans benefits, government retirement pensions, private pensions and other public support programs for survival. The elderly are particularly dependent on cash transfer programs as can be demonstrated by the fact that Social Security contributes more than 50% of the income available to the elderly.

Thus, if the elderly poor are vulnerable in any one area, surely the limitations imposed by the unavailability of work combined with inadequate levels of existing forms of retirement income would take precedence over other serious, but less dominant problems. The income adequacy of elderly Americans (and particularly of elderly poor Americans who are most dependent on government transfer programs such as Social Security) is exacerbated by the current practice of adjusting Social Security benefits according to increases in the Consumer Price Index (CPI). The CPI attempts to show major changes in costs for all goods and services for all age groups residing in different parts of the country. As such, it is not constructed to reflect differences among consumers. However, current studies have demonstrated that the consumption patterns of the elderly vary substantially from those of the non-elderly.

For instance, elderly families and individuals spend a disproportionate amount of their incomes for necessities such as housing, food and medical care. In 1973, the consumption pattern for the elderly population was as follows: (1) housing (32%); (2) food (25%); (3) transportation (15%); and (4) medical care (10%). In a statement before the U.S. House of Representatives Select Committee on Aging on October 1, 1975, Hobart Jackson, Vice President of the National Council on the Aging, described the impact of inflation on the elderly as follows:

> . . . About 78% of elderly males and 92% of elderly females are not in the labor force. Their income is fixed social security and/or pension benefits combined with whatever savings they have been able to build

over the years. Despite the fact that social security payments have been increased in recent years, these increases have not kept pace with the unexpected double-digit inflation. The elderly are particularly hard hit by this inflationary spiral because those items which take up the bulk of their tight budgets—food, housing, medical expenses, fuel and other public utility costs--have suffered the highest cost increases. The aged spend proportionately more of their incomes on food, housing and medical expenses than any other group in this country. A report by the Joint Economic Committee of the Congress concluded that the impact of higher prices on lower income consumers was about one-third larger than on other consumers.

Unfortunately for the elderly, consumer figures for 1980 show that while the CPI rose approximately 12.4% last year, basic necessities showed an increase of over 13.8% with energy rising at 18.1%, food rising at 10.2%, medical costs at 10%, and housing at 15.1%. Interesting enough, non-necessities, or those items defined as all other goods and services combined, rose at less than 9.8%.

Because the limited income of the elderly poor is eroded by the spiraling costs of necessities, some have argued that a separate (and assumedly more equitable) Older Person's Index should be designed to reflect this disparity among elderly consumers. Social Security benefit levels would then be tied to those cost of living increases to which the elderly are most vulnerable. A fairer adjustment of Social Security benefits would affect a large number of America's elderly poor. It is possible that over 55% of the total elderly poor population in America would have benefitted from a Social Security adjustment based on a more accurate reflection of their living expenses.

Supplemental Security Income (SSI) is another source of financial support to elderly poor Americans. A 1978 report indicated that SSI was only serving one-half of its elderly eligible population. This would indicate that one major problem with SSI is its failure to reach large numbers of potential recipients. Although outreach capability is a continuing problem within the SSI program, other operational factors may have equal if not more damaging ramifications for the elderly poor.

Eligibility for SSI is determined by a means test based on an applicant's assets. For an individual, assets cannot exceed $1,500; for a couple, assets cannot exceed $2,250. This is an all or nothing proposition. Thus, if an individual's assets exceed the $1,500 limitation, even by a dollar, he/she is not considered eligible.

Savings are included as countable assets. Unfortunately, this may have the effect of encouraging potential applicants to spend their savings in order to qualify for the program. Once an applicant has been accepted into the program, other income sources will reduce SSI benefit levels. For instance, for SSI recipients who are employed, any earnings over $65 a month will reduce SSI benefits by one dollar for every two dollars earned. In addition, SSI recipients who receive more than $20 per month in unearned income such as Social Security, pensions and veterans benefits will suffer a subsequent 100% reduction in SSI benefits. Although such restrictions may seem logical, one should remember that the maximum Federal SSI yearly income in 1978 was $2,270 for an individual and $3,409 for a couple--both amounts were well below the poverty threshold for that year.

As Girshick and Williamson contend in the following, SSI restrictions may produce the disasterous consequence of excluding the worthiest program recipients:

The inequities of the SSI system are more clearly evident in the assets test. An individual without income and just about the $1,500 in assets will be denied SSI, while an individual earning $300 a month with a $20 pension will still receive a $55.60 SSI monthly benefit. The disperity, in sum, is that an individual below the asset limit can have earnings of $3,000 and receive benefits, while someone without earnings, and just above the assets limit will be denied any benefits at all.

SSI recipients also receive a one-third reduction in benefits if they live in a household with relative(s) in which both shelter and food are provided. This reduction is applied across the board regardless of the number of household residents. In addition, the earned income of certain household residents may also negatively affect benefit levels for the SSI recipient. Both reductions are based on the assumption (apparently unfounded) that related individuals sharing a residence will also share assets.

The cash transfer programs which currently assist the elderly poor do not even assure them of an income equal to the government's own poverty line. In addition, when benefit levels for these programs are adjusted for increases in the cost of living, the inflationary index used does not adequately reflect the living expenses incurred by this group. Until these and other inequities are reversed, the elderly poor will remain vulnerable and dependent.

Recommendations

1. The current practice of adjusting Social Security and SSI benefits to increases in the CPI does not adequately reflect the impact of inflation on the elderly poor. Either the CPI should be revised or a new Older Person's Index designed to more equitably adjust for the living expenses incurred by the elderly poor. All retirement systems should be adjusted bi-annually to reflect the revised CPI.

2. Large numbers of the elderly poor are dependent on Social Security and SSI for their sole or major source of support. These programs do not currently assure the elderly poor of even a minimally secure level of income. As such, the following strategies are suggested.

   - The benefits available through these programs should be raised to provide a level of income which at least meets the government's own poverty line;
   - Cost of living increases in Social Security and SSI benefit levels should not result in decreases in other benefits such as veterans pensions, public housing rents or food stamp bonuses. Social Security increases should not reduce SSI benefits;
   - There should be bi-annual cost of living adjustments;
   - Age qualifications should not be raised;
   - Income requirements for all Federal programs should be based solely on the individual's income regardless of his/her household's income;
   - Displaced homemakers and widows should receive a transistion benefit based on the former spouse's Social Security benefits.

3. SSI should be restructured:

- to either lift or eliminate the assets test as an eligibility factor;
- to lift the allowed earnings level, thereby removing a policy which acts as a disincentive to work;
- to eliminate the one-third reduction in benefits for living with relatives, thereby removing a policy which acts as a disincentive for the growth and maintenance of family support systems;
- to provide for an adequate outreach and information program, including field visits to the homebound elderly, so that more potential beneficiaries will be served; and
- to expand the SSI program into Puerto Rico, the Virgin Islands and the Trust Territories.

RESOLUTION TOPIC--HEALTH SERVICES

Health expenditures in the United States have risen dramatically over the past several decades and represent an increasingly greater proportion of the Gross National Product (e.g., the percentage of the GNP attributed to health expenditures has increased as follows: 3.6% in 1920; 4.1% in 1940; 4.6% in 1950; 5.2% in 1960; 7.1% in 1970 and 8.6% in 1976). The cost of health care for the individual has risen in similar fashion with a $29 per capita expenditure for health in 1940 increasing to a $638 per capita expenditure in 1976. In 1977, the rate of inflation for health care was 50% greater than the Consumer Price Index. Unfortunately, the most recent information available is no better. For instance, the American Hospital Association estimates that community hospital costs for the second quarter of 1980 have increased 15.7% over the same period last year.

The financial security of the elderly has been sorely impacted by the increasing price of health care. Because the elderly are more likely to suffer from chronic disabilities, they incur health care expenses that are extremely high relative to those of other age groups. Even among the non-institutionalized elderly, it is estimated that at least 86% suffer from some chronic form of illness. In 1976, the average health care bill for a person 65 years or older was more than $1,700--an amount which represented more than half of the official poverty level for that year. Thus, in 1976, the elderly spent almost three times the average per capita expenditure for health care.

Medicare and Medicaid are the two major governmental health programs which currently provide assistance to the elderly poor. Even though the national funding level for these programs is massive (in 1976, the combined expenditure for Medicare and Medicaid was $32.4 billion), neither program is capable of responding to the current health needs of the elderly poor. Despite these programs, the elderly spend almost 70% more for medical care than the non-elderly. Currently, Medicare only supports 38% of the health expenses incurred by the elderly. In addition, it is estimated that Medicaid probably serves less than one half of the eligible poor population at any one time.

There are some major problems in the current administration of both programs which negatively impact the elderly poor. Medicare does not cover some important medical services (i.e., prescription drugs, eyeglasses, hearing aids, dentures, custodial care, preventive care, etc.) and Medicaid only provides these services at the option of the state which administers the program (e.g., currently 19 states do not provide adult dental services and 17 do not provide eyeglasses). When these services are not programmatically available to the elderly poor, they must bear the consequent expense.

The most serious problem within Medicare and Medicaid relates to rising health costs combined with increasing demand. Medicaid has grown phenomenally since its inception in 1967. Program expenditures have shown a five-fold increase with a total of $1.9 billion in 1967 up to $9.9 billion in 1979 (both figures represent combined Federal and state amounts). Naturally, beneficiary levels have increased as program costs have increased (i.e., 11.5 million recipients in 1968; 23.4 million in 1976 and 21.7 million in 1978). Nonetheless, as a recent article in the National Journal indicates, inflation has contributed the most to Medicaid's increases:

> . . .Medical care costs slightly more than doubled during that period (1968-1978) according to the Health Care Financing Administration. In addition, the number of beneficiaries nearly doubled, and the payment per recipient even when adjusted for the increasing cost of medical care, rose by a third. Since 1974, however, when the rolls and services essentially stopped expanding, inflation in medical costs has been the real culprit, up by 30% compared to an 11% increase in per patient costs and no growth in the number of recipients.

Current Medicare and Medicaid expenditures indicate that both programs emphasize high-cost, institutional forms of health care which focus on acute or long-term illnesses as opposed to preventive health measures. Both need to abandon their institutionally-biased policies in favor of a more comprehensive, community-based approach to the health needs of the elderly poor, including integration of existing services, increased information and referral mechanisms, and support for preventive health strategies.

Recommendations

1. Medicare/Medicaid should close present gaps in services and benefits by including coverage for diagnostic and preventive services, prescription drugs, dental care, hearing aids and vision care. Transportation to needed health services should be an allowed program cost. All states, including Arizona, should be required to administer Medicaid.

2. Medicare/Medicaid should discourage institutional care except when absolutely required and begin to emphasize a comprehensive, community-based approach which focuses on the day-to-day, life-long health needs of the elderly poor. Suggested strategies include:

   - Supporting alternatives to institutional care including a variety of home health services;
   - Consolidating existing community health services to be more accessible to potential recipients;
   - Establishing and financially supporting educational efforts which focus on the special health needs of the elderly poor. Such programs would be designed to educate health professionals, the elderly poor themselves and the public as a whole.

3. No budget cuts should be implemented in existing federally funded health care services for low-income senior citizens.

4. Legislation should be passed in all states to enable seniors to obtain lower cost generic drugs.

5. All health care institutions should be encouraged to increase participation by consumer representatives on governing boards and by creating advisory councils.

6. The Congress should enact a broad-based comprehensive National Health Insurance program for all Americans, with special emphasis on the elderly poor.

RESOLUTION TOPIC—LONG-TERM CARE

Naturally, the health problems discussed in the previous section also apply to any examination of the long-term care needs of elderly poor Americans. Much of the problem with long-term care must be attributed to limitations in existing services especially in the area of non-institutional alternatives. It is estimated that nearly one-half of the non-institutionalized elderly population suffers from a long-term chronic ailment. However, 83% of the elderly who need long-term care do not require the cost-intensive services available in institutional settings and could be given adequate attention through a home health care program. Thus, the elderly as a whole and especially the elderly poor (who are not financially prepared to purchase expensive health care) desperately need a comprehensive, innovative approach to their special long-term care problems.

Unfortunately, Medicaid, the health care program for the elderly poor, is not currently responding to this need. Because of programmatic restrictions, it is very difficult for Medicaid beneficiaries to qualify for home health care. For an individual to be eligible to receive home health assistance, he/she must have been hospitalized for at least three days, must require continuing "skilled" care and must be classified as homebound. Needless to say, these requirements reflect an institutional bias which is supported by actual program expenditures.

Currently, institutional care consumes 69% of all Medicaid program dollars with 33% going to hospitals and 36% to long-term care facilities. In stark contrast, only 2% of that portion of Medicaid attributable to long-term care is spent for home health care. Ironically, home health care is potentially more desirable, responsive and cost-effective than its institutional alternatives.

In 1979, nursing home care accounted for nearly 45 cents of every Medicaid dollar. This represents a 50% increase in such expenditures as reported for fiscal 1977 and provides further evidence of Medicaid's extreme reliance on institutional care. Given the increasing cost of institutional forms of long-term care coupled with the understandable desire of the elderly poor to remain independent as long as possible, legislators and administrators have a responsibility to carefully examine the impact of current policies and practices and to seriously consider alternative approaches.

Recommendations

1. Medicare/Medicaid should be restructured to discourage the dominance of institutional care and to promote greater flexibility in provision of services which promote the independence of the elderly poor. Suggested strategies include:

- Integrating and consolidating existing community services to provide comprehensive, accessible health care to the elderly poor;
- Expanding current coverage to include preventive health care and to allow the use of medical paraprofessionals;
- Promoting and supporting home-health care alternatives (e.g., homemaker services; adult day care; respite care; Senior Companion; chore services; Green Thumb; etc.) which have proven to be cost-effective;
- Revising program guidelines to allow service variations which compensate for differences in urban and rural areas and low and high-level health needs.

2. When the only suitable alternative is long-term institutional care, the quality and cost of such health care should be monitored and evaluated.

3. Enact legislation to provide tax incentives which encourage families or surrogate families to care for the elderly in their homes, thereby encouraging the extended family model of long-term care.

RESOLUTION TOPIC--NUTRITION

The nutritional problems of the elderly poor may be attributed to a complicated cycle of inter-relationships including economic conditions, physiological status and social environment. In other words, the ability of the elderly poor to obtain adequate nutrition is excerbated by inadequate levels of income, poor physical health, social isolation and limited knowledge concerning nutrition.

The inadequate income available to the elderly poor has already been discussed. Obviously, the financial burden imposed by limited income directly (and negatively) influences the nutritional status of the elderly poor. Food costs are predicted to rise 15-20% in 1981. Most elderly poor depend on fixed retirement incomes which do not adequately reflect the impact of inflation. Food stamp participation among the elderly poor has increased 32% since the elimination of the purchase requirement in 1979. However, if the food stamp program is cut as a result of reauthorization in September, 1981, many elderly poor will be denied access to this important nutritional supplement. Given these economic restrictions, it will be difficult, if not impossible, for the low-income aged to obtain adequate nutrition.

It is important to note that a direct relationship exists between inadequate nutrition and poor health among the elderly poor. More than 85% of Americans who are 65 years of age and older suffer from a chronic disease or disability. At least half of these diseases (i.e., coronary heart disease; hypertension; diabetes; arteriosclerosis and obesity) are directly associated with malnutrition. Finally, chronic health conditions often impose strict physical limitations which may make food preparation impossible.

At least two-thirds of the elderly poor live alone. Since isolation may act as a disincentive for preparing regular, well-balanced meals, the social condition of the elderly poor may negatively impact their nutritional adequacy. Transportation is often limited or unavailable to the elderly poor. Therefore, isolation imposes a further complication, limiting/access to food sources and nutrition sites. Finally, even given sufficient income and access to food, the elderly poor may not possess enough knowledge concerning their nutritional needs to assure themselves of a healthy diet.

Recommendations

1. Low levels of income, poor physical health and social isolation negatively impact the ability of the elderly poor to obtain adequate nutrition. Government-funded nutrition programs such as congregate meal sites and home-delivered meals often provide the most important source of nutrition to this population. To assure that larger numbers of the elderly poor are served by these programs, the following is suggested:

   - Increased funding levels;

   - Better coordination and integration of existing nutrition services;

   - Better coordination of existing transportation services to nutrition sites and food sources;

   - Nutrition program advisory councils are mandated to have 51% client participation. Insure that 30% of that 51% are low-income elderly;

   - Title III of the Older Americans Act should require that nutrition education be provided to participants at all nutrition sites.

2. Food costs are predicted to rise 15-20% in 1981. Food stamp allotments should be adjusted bi-annually to more adequately reflect the inflationary cost of this essential item. The food stamp program should continue operating at levels which are sufficient to serve the needy and particularly the elderly poor.

RESOLUTION TOPIC—ENERGY

Although the rising cost of energy continues to be a major source of concern to all Americans, it poses a serious and sometimes life-threatening problem to the elderly poor. Unfortunately, certain conditions prevalent among the elderly poor make them especially vulnerable to increases in energy costs. Because over 75% of elderly Americans are unemployed, subsiding on fixed retirement incomes which have not kept pace with inflation, they are financially unprepared to absorb rising energy costs. In the past, elderly poor households attempted to treat heating and utility costs as a variable expense by reducing consumption. However, current statistics indicate that this is no longer a feasible (and, perhaps, more importantly, a healthy) alternative for the elderly poor.

Low-income families spend 15% to 20% of their income on fuel and utilities in comparison to middle-income families who spend approximately 5% of their income on residential energy costs. Why do the poor spend a disproportionate amount of their limited income on residential heating and utility costs?

Data collected from the 1970 Census indicate that 63% of elderly homeowners live in houses constructed prior to 1940. Older homes are less likely to be energy efficient. Yet, because of limited incomes, the elderly poor are less likely to invest in energy-saving repairs and improvements. The elderly poor are also more dependent on the least efficient, most expensive home heating fuels. In addition, most elderly poor are home throughout the day and cannot turn down their thermostats to reduce energy consumption during working hours. Nonetheless, some homebound elderly do reduce interior temperatures during the day to conserve on energy costs. However, this is a dangerous practice for the elderly who are particularly vulnerable to hypothermia, a loss of body temperature which can be fatal.

The elderly have the unfortunate distinction of spending a greater percentage of their income on heating than any other group. Nonetheless, while they spend more on energy costs, the elderly poor actually consume less energy than any other group. In other words, the elderly poor are less likely to be able to reduce consumption in order to reduce energy expenditures.

From 1972 to 1979, fuel costs rose 197.3% and will continue to rise. This has caused considerable hardship to the elderly poor eroding their financial security and impacting their ability to purchase other necessities (i.e., food; medicine, etc.). Ironically, as low use energy consumers, the elderly poor are also subject to the service inequities incorporated in existing utility rate structures. The impact of high energy cost is not a short-term, acute problem for the elderly poor. Instead, it continues to pose a chronic threat to their health and security. As such, this problem deserves a response which is comprehensive, not simply crisis-oriented.

Recommendations

1. The U.S. Congress should enact legislation authorizing the Federal government to create a year-round fuel assistance program which gives priority to elderly poor and near poor consumers.

2. The Federal government should require Federal and state public utility commissions to implement new rate structures such as lifeline rates for elderly poor consumers, simultaneously eliminating lower utility rates for high use customers. In addition, national guidelines should be established for the home heating industry including standards for customer service, debt collection and disconnections.

3. Congress should increase funding for weatherization activities with the goal of adequately weatherizing all low income elderly residences. Program guidelines should be revised and expanded to allow flexibility in obtaining labor with the goal of hiring the elderly poor whenever possible. In addition, Congress should:

   - Provide necessary funds for retrofitting heating and cooling systems or conversion to alternative sources;

   - Strive to maintain independent/non-corporate control of alternative energy sources;

   - Expand the weatherization program to include routine, annual maintenance of heating units in low-income elderly residences.

4. The Federal government should require evaluation of all federally-funded energy programs which serve the elderly poor to determine sufficiency in service, actual administrative costs and community needs.

RESOLUTION TOPIC--TRANSPORTATION

Because the elderly poor are likely to suffer from physical impairment which reduce mobility, they are often completely dependent on others (i.e., public facilities; service agencies; relatives; volunteers; etc.) for their transportation needs. It has been estimated that at least one-third of the elderly poor population experience serious transportation problems.

The availability of elderly transportation through social agencies and volunteers has been sorely impacted by the rising cost of gasoline and insurance premiums. Because provision of transporation requires increasing amounts of program funds, the level and quality of direct services may be seriously reduced (the other alternative is to cut transportation). In addition, when volunteers are asked to bear the full cost of their services, the number volunteering diminishes.

When transportation cannot be acquired through social agencies, volunteers or relatives, the elderly poor must turn to public facilities. Because they subside on reduced and inadequate incomes, many cannot afford such services even when available and accessible. However, they must deal with the further complication imposed by design problems inherent with most existing public transportation vehicles.

Perhaps, the most serious problem concerning transportation for the elderly poor is its simple lack of availability. Although millions of Federal and state dollars are earmarked for transportation each year, these programs have not addressed the transportation needs of the elderly poor. Unfortunately, due to fragmentation and lack of coordination, the capacity of existing transportation services has not been adequately tapped.

Recommendations

1. Transportation services should be developed to accommodate the broad range of needs of the elderly poor. Integration and coordination of existing transportation services is required to assure a more effective utilization of current facilities. Suggested strategies include:

   - Elimination of program guidelines requiring user restrictions based on age, health status, income, geographic limits, etc.;

   - Increased funding to subsidize reduced fare programs so that public transportation will be more accessible to the elderly poor;

2. Rising gasoline costs and increased insurance premiums negatively impact the amount of transportation services provided by social agencies and volunteers. Such service providers should be compensated by:

   - Raising program funds to cover the increasing level of expenditures required to support transportation costs;

   - Raising the Federal tax deduction allowed for volunteer transportation services;

   - Requiring state and local governments who receive Federal transportation funds to provide incentives such as tax-free or low-cost fuel, reduced rates for parts and maintenance, etc.

3. When coordination and integration of existing services and facilities is not sufficient to provide necessary transportation to elderly poor populations, funding should be provided for special transportation systems. Such services should be available to the elderly poor through a sliding scale fare system.

RESOLUTION TOPICS--EMPLOYMENT AND THE WORK ETHIC

Over 75% of all persons 65 years or older receive no wages or salaries and depend on Social Security, Supplement Security Income, veterans benefits, government retirement pensions, private pensions and other public support programs for survival. Poor families are even more dependent on non-earnings since 88% of their income is derived from a mix of public sources. In comparison, earnings constitute 80% of the income of the non-elderly. The elderly comprise a mere 3% of the entire U.S. labor force. In fact, the rate of employment for elderly men has shown a steady decline since 1900 when two-thirds of the elderly male population held jobs. In contrast, only one-fifth of elderly men worked in 1978.

Obviously, some elderly Americans may wish to enjoy their retirement years without working. Others may not be physically capable of maintaining a job. Unfortunately, the elderly poor, by definition, desperately need to supplement their inadequate incomes. For the healthy elderly poor, job opportunities could provide the additional income needed to assure them of a more secure existence. However, if employment rates reflect the availability of job opportunities, the elderly do not fare very well.

Besides limited job opportunities, the elderly poor must contend with administrative policies designed to reduce benefit levels available from programs such as Social Security and SSI according to the amount of income earned by beneficiaries. Sometimes, the allowed earnings level is so low that the elderly poor have no choice but to defer working. Such policies pose a serious problem to the elderly poor and act as a disincentive to employment.

Recommendations

1. To assist the elderly poor in obtaining jobs, thereby increasing their financial security and reducing their dependence on governmental cash transfer programs, the following strategies are suggested:

    - Provide training and retraining and long-term employment at minimum wage or higher to low income elderly (with special emphasis on elderly poor women) using both government and private sector resources;
    - Support employment alternatives such as job sharing, part-time work and flexible hour provisions to meet seniors' special needs;
    - Provide tax incentives within the private sector for hiring the elderly poor;
    - Establish guidelines for preference hiring of the low income elderly; and
    - Strictly monitor and enforce existing civil rights laws which protect the employment rights of the elderly.

2. Establish a national educational effort, using all possible local, state, and national organizations, to focus on the under-utilized but essentially unlimited resources of the elderly population and to emphasize the advantages of hiring the elderly poor. In addition, require all federally-funded agencies to receive sensitivity training on the concerns of the elderly poor.

RESOLUTION TOPIC--HOUSING

The most critical housing problems facing the elderly poor are the availability and affordability of safe shelter. As is the case with other necessities of life, housing costs take a proportionately higher stake of income as income declines. On average, housing accounts for 29% of the annual budget of the elderly.

Most of the elderly are homeowners (71%). The housing of approximately 2 million elderly families is physically inadequate (1977 Housing Survey). However, Federal housing programs for low income people focus on rental housing. The only program serving elderly homeowners is the Farmer's Home Administration very low income home repair loan and grant program. The program assisted a mere 7,500-10,000 households in 1979. Therefore, existing housing programs do not address the problems of elderly homeowners who have had to absorb substantial increases in property taxes, maintenance and utility costs over the past decade.

Elderly renters have faced increased housing costs as well. Rents have been pushed up by inflation while substantial numbers of rental units are being converted into condominiums at prices beyond the reach of people on fixed incomes. Public housing provides no real relief to elderly renters forced out of high cost or converted apartments since only 2% of the nation's elderly population benefit from public housing (despite the fact that the elderly occupy approximately 45% of the available public units). There is simply not enough public housing or low cost private rental property to accommodate surging demand from the ranks of the elderly poor.

Recommendations

1. Increase funding under existing or new housing legislation for new construction and/or renovation of existing housing stock for low income elderly including single-family units, low-rise units, mobile units and low income retirement communities. To facilitate the above, it will require expansion of low-interest loan programs, establishment of tax credits for rehabilitation and expansion of weatherization services.

2. Standing governmental task forces should be established at the Federal, state and local level to attend to the concerns of the elderly poor regarding housing. Task force responsibilities should include: monitoring neighborhood revitalization programs to ensure continued housing occupancy by elderly persons; monitoring and initiating housing laws in the interest of low income people; monitoring and assuring enforcement of non-compliance penalties contained in existing or future housing laws for managers of public and private housing and formulation and distribution of housing information to elderly poor homeowners and renters.

3. Establish a national minimum housing code for all low income housing units.

RESOLUTION TOPIC--URBAN AND RURAL SERVICE DELIVERY

Delivery of services to low income elderly people in both urban and rural settings is a critical concern to this group, a concern that is expressed in each of the topic areas discussed previously. Rather than reiterate those concerns here, a brief overview of service delivery problems in urban and rural areas will be provided.

Of the 55% of the nation's elderly population living in cities, black and other minority elderly (with the exception of American Indians) are represented to a degree not found outside urban areas. Large percentages of these population groups, along with their white elderly counterparts, have needs which are underserved due to several factors: inadequate information on available services, fear of crime, isolation, and inadequate transportation. Often providers of services to urban elderly find their budgets constrained due to cutbacks at the Federal and state levels and eroding tax bases which cause consequent reductions in municipal revenues.

Recommendations

1. Better coordination is needed among aging service organizations which have overlapping geographic or political boundaries (counties and cities, for example) to increase efficiency and breadth of services provided to the elderly poor. Planning and administrating agencies should insure that service sites be accessible to target populations.

2. Federally funded urban programs should be designed to include multi-year funding to insure adequate and consistent service provision, including an escalation clause to cover cost increases. Regulations for such programs should be clear and intelligible to prevent conflicting interpretations.

3. Congress should enact legislation to establish minimum standards of training and experience for staff funded through the Older Americans Act. Such staff who provide services in outreach and nutrition should be trained to accommodate the needs of culturally diverse urban elderly populations.

4. Congress should establish a national crime prevention program targeted for the protection of the elderly, using and expanding existing programs whenever possible.

5. City police departments should intensify the formation of neighborhood "community watch" programs in inner cities, and provide "operation life-line" telephone service to all law enforcement agencies.

6. Funding should be provided to promote the establishment of multi-purpose senior centers.

7. Funding should be increased for subsidized taxi services. Existing regulations which provide for a barrier-free environment should be monitored and enforced.

8. A federally funded information and referral program should be established in all cities, emphasizing outreach and follow-up through existing agencies.

The rural elderly poor have manifest problems of their own. Most of these relate to program funding inadequacies. As recently as 1979, rural areas benefitted from only 11% of the total funds appropriated to the Administration on Aging. Although approximately 50% of the nation's poor reside in cities, metropolitan areas receive a disproportionate share (75%) of Federal funds, causing consequent funding disperities in rural areas.

During the 1970's, the per capita Federal outlays attributable to metropolitan counties for health services, welfare payments and worker training and development expenditures represented up to four times the amount allotted to nonmetropolitan counties. This disperity in rural funding levels may be explained in part by the simple failure to agree on a consistent definition of the term, "rural".

The problems of the rural elderly poor are further complicated by shrinking tax bases and inadequate local resources. Even if a rural community is prepared to administer an elderly program, it may not be able to acquire the necessary matching funds.

Recommendations

1. Establish new systems for the intra-state distribution of Federal funds for aging and income-related programs so as to reflect geographic distribution, population density, and services needed by the elderly poor population of the state, simultaneously adopting a consistent definition of "rural."
2. Enhance and expand existing transportation components of elderly service programs either by taking services directly to program recipients (mobile service delivery units) or by providing transportation of the elderly to service sites.
3. Increase funding earmarked for rural areas to expand health services, legal aid and crime prevention programs.
4. Increase funding to expand existing outreach services so that the rural elderly poor will have better access to all available programs.

PRIORITY CONCERNS OF THE ELDERLY POOR

All mini-conference delegates were given a questionnaire to complete at their convenience during the course of the conference. Of the 350 questionnaires distributed, 184 or 55% were returned and tabulated. Questions were divided into two principal categories: personal background and issue concerns. Outlined below are the results of the issue concerns' section. Delegates were asked to rank on a scale of 1 (not very important) to 9 (very important) those issues with greatest impact on the well-being of both themselves and on other low income seniors. The average rating of the issue concerns is shown and issues are ranked in order of highest average score.

Problem Area	Average Rating	Rank
Income--Availability of adequate finances to meet needs.	8.424	1
Transportation Services--Availability of rural and/or urban transportation services.	8.228	2
Physical Health--Availability and adequacy of health services.	8.209	3

Problem Area	Average Rating	Rank
Outreach Services--Availability and adequacy of information concerning human and social services for the elderly poor.	8.133	4
Nutrition--Availability of congregate meal sites for the elderly poor.	8.129	5
Homemaker Services--Availability and adequacy of homemaker assistance to the elderly poor.	8.110	6
Nutrition--Availability of home-delivered meals for the elderly poor.	8.075	7
Health--Availability and adequacy of home health services.	8.033	8
Nutrition--Availability of good and adequate meals	7.956	9
Health Insurance--Adequate protection from excessive health care expenses.	7.946	10
Weatherization Services--Availability and adequacy of services which improve the energy efficiency of housing.	7.913	11
Accessibility to Existing Services--Location and convenience of services available in your community.	7.911	12
Crime--Safety of person and property.	7.900	13
Rental Housing--Availability in cities and small towns of low-rent rural housing for the elderly poor.	7.880	14
Energy Assistance--Availability of assistance for heating and cooling bills.	7.848	15
Long-term Care--Availability of long-term care assistance.	7.824	16
Housing--Availability and adequacy of home repair and improvement services.	7.755	17
Volunteer Work--Opportunities to provide volunteer services.	7.455	18
Legal Aid--Assistance with legal problems.	7.419	19
Mental Health--Availability of mental health services.	7.293	20
Employment--Opportunities to work.	7.239	21

Problem Area	Average Rating	Rank
Water and Sewer Systems--Availability and adequacy of water and sewer services in your community.	7.143	22
Nutrition--Availability of individual and/or community gardens and canning projects.	6.609	23

Among the several conclusions that might be drawn from these survey results, two have been isolated as representative of the tone and substance of the mini-conference.

First, the elderly poor as a group strive to maintain an independent, non-institutionalized life style. As is the case with people of any age or income, low income elderly people would prefer to take care of themselves--if equipped with the resources and support systems to do so. Most recognize that independence results from, as one delegate put it, "the means, the money and the strength" to sustain it.

Access to transportation, ranked second in the survey, is an essential means to obtaining needed goods and services. Money, number one item in the survey, is, of course, the basis of security. Strength, used here to refer to the capacity to sustain good health, provides the motivation for independence. Unfortunately, many aging policies, developed and implemented with the best intentions, contribute to the dependence and continued vulnerability of the elderly poor. Such policies need to be examined and replaced with alternative strategies which sustain and promote self-sufficiency.

The median score on the survey is 7.913 on the 9-point scale. No item is rated lower than 6.609. The survey respondents feel strongly about all the issues cited and no doubt about many others which were not included. It may be difficult for the general population to perceive the precariousness and sense of vulnerability experienced by the elderly poor. It is perhaps easier to comprehend if one takes into consideration the interaction of two characteristics: advanced age and declining income. Growing older does not in and of itself promote vulnerability. In many societies, being elderly connotes seniority and power. However, the physical limitations and diminished health experienced by many elderly considerably reduce their capacity to resist poverty. The combination of advanced age and low income, therefore, is a powerful deterrent to security and independence, and its effects can be devastating.

CONCLUSION

The Special Concerns Session of the 1971 White House Conference on Aging concluded that, "America must address itself first to the needs of the elderly poor." Ten years later this is still an appropriate conclusion. While the lives of most elderly Americans have been enhanced over the last decade by a multitude of programs and policies designed to aid them, there remains in the nation a significant population whose needs are underserved and whose potential is underutilized.

The 1981 White House Conference on Aging will be the fourth conference on aging since the initial one in 1950. Each of these previous conferences stimulated subsequent aging policies and strategies. Given the implications of a rapidly aging society, the recommendations of the 1981 Conference are even more important today in developing a comprehensive, responsive and innovative national policy for the elderly. It is imperative that the special needs of the poor be addressed within that national aging policy. Furthermore, the programs stemming from that policy must give priority to serving the poor, the most vulnerable among the elderly.

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Mini-Conferences have been recognized by the 1981 White House Conference on Aging and convened by organizations that wished to focus attention on special aging issues.

Recommendations of mini-conferences are not the recommendations of the official delegates to the Conference or the U.S. Department of Health and Human Services. They represent the views of the participants in the mini-conferences. They are being made available to the delegates as part of their background materials for the national conference.

The following Mini-Conference Reports have been published:

Recreation. Leisure and Physical Fitness
Aging and Alcoholism
Energy Equity and the Elderly
Public/Voluntary Collaboration: A Partnership in contributing to independent living for the aging
National Health Security
Concerns of Low-Income Elderly
Vision and Aging
Alzheimer's Disease
Arts, the Humanities and the Older Americans
Older Women
Life-Long Learning for Self-Sufficiency
The Urban Elderly
Rural Aging
Long-Term Care
Non/Services Approaches to Problems of the Aged
Spiritual and Ethical Value System Concerns
Transportation for the Aging
American Indian/Alaskan Native Elderly
Pacific/Asian Elderly "Pacific/Asians: The Widsom of Age"
Environment and Older Americans
Rights of the Institutionalized Elderly and the Role of the Volunteer
Veterans
Mental Health of Older Americans
Saving for Retirement
Hispanic Aging
Challenging Age Stereotypes in the Media
Oral Health-Care Needs of the Elderly
Housing for the Elderly
Consumer Problems of Older Americans
Senior Centers
Elderly Hearing Impaired People
Black Aged
Legal Services for the Elderly
Simplifying Administrative Procedures and Regulations in Programs Affecting the Elderly
Intergenerational Cooperation and Exchange
Self-Help and Senior Advocacy
Euro-American Elderly
Inter-relationship of Government, Private Foundations, Corporate Grant-Makers and Unions
"The National Dialogue for the Business Sector"
Foot Health and Aging
Pacific Islanders Jurisdiction
Gerontological Nursing

the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on
Elderly Hearing Impaired People

MCR-8

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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Elderly Hearing Impaired People

I. INTRODUCTION

More than ten million older Americans suffer some degree of hearing loss. As our older population grows, hearing loss can be expected to assume greater magnitude and to compel increasing attention.

At a time when there is a growing demand for more satisfaction from life, large numbers of hearing impaired people find the quality of their lives profoundly diminished.

Many disabilities handicap us in our environment, but hearing impairment strikes at the very essence of being human--it hinders communication with other human beings. It restricts our ability to be productive and to engage in social intercourse. It reduces our constructive use of leisure time. Hearing loss often leads to poor self-image (particularly among the elderly), to isolation, and to despair. It affects our mental and physical health and, ultimately, our will to live.

The majority of older people live with families. Hearing loss creates tension in the family. As the number of 3-generational families increases, the tension factor of hearing loss could become overriding. People affected by this trend constitute a very large portion (perhaps 40%) of our population.

Many older people continue to live alone. Hearing impairment poses a major threat to their ability to function independently.

For those older persons who are institutionalized or in nursing homes, hearing loss may have contributed to their being where they are.

"Hearing impaired" is a generic term that includes both deaf and hard of hearing people. At least four categories of older people with hearing loss need increased investigation: a) persons with age-related hearing impairments; b) persons who lost some but not all of their hearing as adults; c) deafened adults; and d) prevocationally deaf (onset prior to 19 years of age). Although people in each category have many similar experiences, there are significant differences among them that require greater awareness and understanding from all of us.

Many of our health delivery systems have been designed to respond to a diagnosis rather than to a functional disability. With the wide range of hearing loss in older people, concern for the person's ability to cope becomes crucial. An obvious inability to cope should elicit a response from family and community, which would include public and private elements of society.

WE ARE AT THAT POINT TODAY WITH MILLIONS OF OLDER PERSONS WHO ARE HEARING IMPAIRED.

Much has been written about the tendency of older people to withdraw from familiar life patterns and eventually to become isolated. There are many roads to isolation, but one of the shortest (and fastest) is loss of hearing.

The situation is getting worse. As we move from an industrial to an information society, the key resource becomes what is in our heads. But what is in our heads today, and will be tomorrow, gets there largely in the sound mode. As the telephone, radio, and television brought new access of information to most people, they posed increasingly difficult problems for older persons with hearing loss. In the "global village" of our electronic world, hearing impaired people live in the ghetto.

The largest single group of older Americans has an invisible condition--hearing loss. It is a condition that is underestimated. Those who have it are either unserved or underserved. Neither the condition nor person affected is understood.

With this in mind, a White House Conference on Aging Mini-conference on Elderly Hearing Impaired People was convened to develop the issues and a plan of action so that solutions can be found and implemented.

II. DESIGN OF THE MINI-CONFERENCE

Self Help for Hard of Hearing People, Inc. (Shhh), planned, organized, and convened the Mini-conference. Shhh is a volunteer, national organization of hearing impaired people. It is a nonprofit, nonsectarian, educational organization devoted to the welfare and interests of hearing impaired people. It concentrates on hard of hearing people but welcomes deaf members as well. Shhh was assisted in varying degrees by ASHA, the American Speech-Language-Hearing Association; NAD, the National

Association of the Deaf; and AGB, the Alexander Graham Bell Association for the Deaf. Seven other national organizations supported the Mini-conference by helping to publicize it and/or by sending delegates to it.

The Mini-conference was designed so that hearing impaired people would be able to participate in all aspects of the proceedings. Four separate and innovative communications systems were installed so that those who can benefit from amplification--with or without a hearing aid--would have such an opportunity. Sign language and oral interpreters were provided for those who are deaf. Visual facilitation flip charts were also utilized.

Into this setting came forty-six women and forty-two men from twenty-five states. Of these eighty-eight people, forty-four are hearing impaired. Every activity had two chairpersons, one hearing impaired and one hearing. Of the eight persons who reported the findings and recommendations of each group to the full conference, four are hearing impaired and four are hearing.

For the first time in our history, hearing impaired people, deaf and hard of hearing in varying degree, joined with hearing people at the national level to discuss issues of concern and to make recommendations for improvement.

Also involved were the forty-four hearing participants from government, industry, and academia. Included among them were members or representatives of the hearing health team: the physician, the audiologist, and the hearing aid specialist. Various organizations involved in the delivery system of hearing health care, or in areas that influence it, were represented. Organizations whose areas of interest include both the elderly and hearing impairment participated as well.

One evening and two full days of testimony (20 hearing impaired consumers from 15 states), workshops (four), and presentations (nine) provided extensive examination of issues and the basis for conclusions and recommendations. Oral input was received from fifty-eight official delegates during the Mini-conference. The other thirty persons participated in varying degrees. Written input was accepted for consideration through January 27, 1981 (two weeks after the Mini-conference).

III. DISCUSSION AND CONCLUSIONS

A. Research

1. Biomedical

Too often, hearing loss has been considered a normal liability of aging. Perhaps that is why we know so little about its prevention. To examine this subject in depth, we obtained the cooperation of a leading researcher in the field of genetic diseases affecting children. We asked him to apply his experience and skill to research into the genetics of hearing loss in the elderly.

In a paper presented at the Mini-conference, Robert J. Rubin, M.D., developed the basis for concluding that there is reasonable indication that a large portion of hearing loss in the elderly probably has its roots in genetic disease. We know little about prevention, cure, and care of hearing loss in the elderly. The term presbycousis is neither a diagnosis nor a disease. Hearing losses associated with aging are caused by many known different diseases. But, in many cases, the cause is unknown.

Dr. Rubin's research showed that the pathological process is usually death of the cells of the organ of corti. These cells are injured by processes which occur during life. Since the cells are alive for some period of life, we need to determine why they die. Intervention might then be developed to prevent death of the cells. Dr. Rubin concluded that, "Genetic diseases usually involve an abnormal biochemical process. Research to define these abnormal biochemical processes which affect the aging cells of the organ of corti would then be able to prevent a hearing loss in probably more than 50% of the hearing impaired population over 65 years of age . . . ." A very encouraging conclusion!

2. Behavioral and Social Science

a) Dr. Robert Butler once commented that we have somehow brainwashed ourselves into thinking that working with children is more rewarding than working with older people. There is ample evidence to show that health professionals are not sufficiently involved in work with the elderly. In view of the growing need for more health service providers to be involved with older hearing impaired people, we examined the usefulness of empathy training.

Empathy allows us to be sensitive to and aware of the needs and values of others, even though they may be different from our own. In the health-related professions, empathy is viewed as an "essential core dimension of all helping endeavors."

Based on examples of research and demonstration projects conducted at the University of Arkansas, it was found that people can be trained to empathize. By developing a perceived similarity between service providers and hearing impaired elderly, by sharing in the experiences of the latter, and by experiencing the negative reactions of others to them, we can be made more responsive to their situation and needs.

Although merely a beginning, empathy research holds out the possibility of helping change attitudes towards older hearing impaired persons. This, in turn, leads to a more knowledgeable service provider who then may be more willing to work with older hearing impaired people in developing effective communication.

b) A second subject discussed in the area of behavioral and social science research had to do with counseling of elderly hearing impaired people. A distinction was made between those with lifelong impairment and those whose onset of hearing loss occurred in later life. The latter are in "double jeopardy" and experience a more devastating kind of change because of having to face the problems of aging and hearing loss at the same time. Counselors need to be more aware of and better informed on some of the complexities of this group.

Theoretically, older people who lose their hearing face (at least) two major changes in their lives and consequently may have greater vulnerability to the stress of such changes. They may have greater problems of maintaining a sense of equanimity, of coping.

c) Carrying this a step further, could hearing loss be life-threatening? It is agreed that loss of hearing can lead rapidly to withdrawal and isolation. If we perceive ourselves to be in a state of isolation, do we relax our grip on life? Do we open ourselves to greater vulnerability to more serious problems such as cancer or heart disease? There is sufficient linkage in this sequence to warrant further research.

d) The so-called "denial syndrome" was discussed, with everyone agreeing it exists but disagreeing considerably about why the hearing impaired deny their hearing loss. To the usual stigma--fear, vanity, etc.--was added negative professional attitudes, which in turn cause negative responses in the person with the problem. This is an emotion-laden subject which would benefit from a more detached examination. It is important because denial, for whatever reason, impedes constructive solution.

e) An examination of environmental factors which complicate an existing high-frequency hearing loss was said to have changed the ways in which some audiologists provide services. In addition to aural rehabilitation and the teaching of speech reading, we added adjustments in speaking and adjustments in the environment which facilitate the hearing impaired person's ability to cope.

3. Technological

Among those persons who benefit from amplification there is a consistent complaint about the quality of hearing aids. This complaint often centers on the problem of background noise.

In fact, there are innovative means of putting existing components together in a way which provides the listener with a capability to minimize background noise. Various options were demonstrated at the Mini-conference which rely on existing technology but are not generally used in the miniaturized hearing aid. The point made in these demonstrations was that if you can benefit from amplification there are many ways of doing so and the standard hearing aid is only one, and not necessarily the best, among them. Innovative approaches for new types of solutions to these problems was encouraged.

Research into better hearing aids utilizing the current state of electronic art was stressed.

Another attempt at "the Generalized Signal Processing Hearing Aid" with patent pending was submitted for our review. The author was unable to attend the Mini-conference.

B. Health Services

1. Access and Availability

a) Places of delivery

(1) Institutional

Less than 5% of our elderly are in nursing homes. But that means more than one million people. Professionals at the conference estimated that perhaps 90% of these people are hearing impaired.

Despite the fact that there are many inexpensive ways for improving communications with persons in nursing homes, retirement homes, hospitals, etc., these opportunities are not being utilized. Many symptoms of hearing loss in the elderly are similar to those symptoms which may be incorrectly interpreted as senility. In fact, some people are in nursing homes simply because of their hearing impairment, and for no other reason.

How does it feel to be declared incompetent when you are only hearing impaired? What impact does that have on the person?

Staff in many institutions, as well as social workers, psychologists, and rehabilitation counselors in general, often lack experience with hearing impaired persons. They may not be able to differentiate between symptoms of senility and those which have an otological basis.

Much more in-service training is required. Hearing screening of anyone over 55 should be encouraged. Family and friends of persons in nursing homes should be made aware that utilization of competent hearing health services may be a viable alternative to institutionalization. The savings in human and economic terms could be profound.

(2) Non-institutional

Not enough effort is made to reach those who do not seek help. We have an abundance of theories and explanations of why older hearing impaired people are slow to seek, and sometimes never seek, help. We need to find them and help them. Perhaps identification and assessment of the various elements of daily life routine would point to those which lead us to older hearing impaired people. Some communities do better than others. How can we share experience on a national level? We must strive for awareness on the part of local communities that they have a responsibility to ensure that older persons do not lack care because they are unable to provide it themselves.

Isolation can take place in either rural or urban settings. It can occur in a variety of living arrangements. But if the person is alone physically, the problem can be compounded.

Utilization of mobile vans to provide local screening tests, development of community emergency systems for frail elderly (which would include hearing impaired) people, cooperation with senior centers in outreach efforts--all are ways in which we can locate and better serve our older citizens who are hearing impaired.

2. Training

It is clear that a great many service providers are limited in their knowledge and experience with older hearing impaired people. The physician (general practitioner) may know little about hearing loss or gerontology. The otologist and the audiologist know something about hearing loss. They may know little about gerontology. The hearing aid dealer has contact with older people with hearing loss, but he or she is limited in the kind of training that providers of service to the elderly should receive.

Professional curricula, in-service training (empathy training included), regional workshops--all should be expanded to include adequate training in both gerontology and hearing loss to permit, at a minimum, recognition and referral to a person competent to handle the problem.

Empathy training could alleviate tension and difficulty in families. It would help policy-makers in the public sector to be aware of hearing loss--its complications and its impact on millions--and to bring it into perspective with other health problems when establishing priorities for action.

Training is needed as well for those who are hearing impaired. Community colleges could provide courses (using hearing impaired peers) to develop a common-sense understanding of how to handle oneself in various life situations. Aural rehabilitation and training in assertiveness are very helpful to hearing impaired people.

Centers for information on and training in the use of assistive devices are needed.

3. Costs and Financing

In America today, when you get old you get poor. If you have been hearing impaired awhile, you were probably poor before you got old. In any event, the costs of hearing health care are too high to permit most older persons to avail themselves of it.

a) Hearing aids

We recognized that extensive examination of this subject was accomplished by a series of reports going back to 1968, e.g., Hearing Loss, Hearing Aids, and the Elderly, Special Committee on Aging, United States Senate, July 1968; Final Report to the Secretary on Hearing and Health, Department of Health, Education, and Welfare, Intradepartmental Task Force on Hearing Aids, July 1975; and the Hearing Aid Industry Staff Report, Final Report to the Federal Trade Commission on Proposed Trade Regulation Rule, Bureau of Consumer Protection, Federal Trade Commission, September 1978. Despite these studies and recommendations, corrective action on identified problems has been slow and uneven.

Testimony of twenty hearing impaired consumers from fifteen states indicated persistence of old problems. Complaints about price, fitting, quality of merchandise and of service were common. Professionals and hearing aid dealers bore the brunt of this criticism. But overriding was the desire to receive a better hearing aid at lower cost.

b) Means of financing hearing health care

Medicare will pay for a diagnosis, if requested by a physician, or an evaluation of hearing loss. It will pay to tell you you have a hearing loss, but it will not pay to correct it. Hearing aids and related services are among the very few kinds of health-related services specifically excluded from Medicare. Persons over 65 with hearing impairments seem to be the least served.

Actually, in 1981 this is shortsighted. When we were talking about early retirement and escalation of social programs while productivity decreased, perhaps the cost factor to the U.S. Government was, indeed, exorbitant. But now and in the foreseeable future we are engaged in an effort to increase productivity and to keep people in the work force longer. Seventy-two percent of the 16.2 million people who are hearing impaired are over 45 years of age. That is close to 12 million people. The reduction in productivity and consequent loss to the U.S. Government from many millions of people with uncorrected hearing loss is huge. The costs of auditory training, purchase of hearing aids or other acceptable devices already available, and aural rehabilitation would be returned to the U.S. Government several times over by expanded longevity of hearing impaired people in the work force. Furthermore, hearing aid consumers need not receive hearing aids from dealers and thus pay high prices for them. The Government might contract with manufacturers to make large lots of professionally designed master-type hearing aids which would lower costs considerably. Just as veterans have earned more money (because of the G.I. Bill of Rights) and paid more income tax, so can older Americans who are hearing impaired continue to contribute to the country's needs if creative solutions to some of their problems are developed.

Another possible aspect of this kind of solution to high costs for the consumer is for anyone made eligible under Medicare to pay a portion of the cost, thus eliminating acquisition of a hearing aid just because it is free.

c) Special needs of the deaf

Older persons who have been deaf all or most of their lives may have been limited in their educational development. Their ability to earn and develop a retirement base is usually severely restricted. They face their later years with inadequate financial resources. Special efforts should be made in vocational training programs for deaf people to help prepare them for this later stage in life. Various government agencies such as the Social Security Administration should make a concerted effort to be certain older deaf people are fully aware of benefits for which they qualify.

C. Physical and Social Environment, and Quality of Life

The quality of life depends greatly upon interpersonal relationships. It is in this context that we are born, live, and die. It is here that the human spirit manifests itself in all its strengths and weaknesses. Hearing loss impairs anything that can be manifested only in terms of our relationships with others, which in turn depend on our communication with them.

1. Communications Access

a) Benefiting persons with partial but significant hearing loss

(1) Systems requiring some modification of the environment

The Mini-conference site was equipped with several different communications systems. Among them were: a) Audio-loops. The user must have a hearing aid with a telephone (T) switch. The signal is received from an electromagnetic field in an induction mode; b) Infra-red. The user was provided with a special receiver to take the signal from infra-red rays which fill the area from emitters; c) Ampli-sound. The user was provided with a radio receiver with earplug (a regular transistor radio is adequate). The signal is taken from a prescribed AM radio frequency. Both Infra-red and Ampli-sound can be used with or without a hearing aid. All the systems cut out background noise.

These systems range from inexpensive (Audio-loops) to moderately expensive (Infra-red), both of which have been described by the American National Standards Institute as being acceptable forms of communications access. Ampli-sound is equally acceptable.

These three systems require minor modification of the environment in which they are used. They are practically maintenance-free. By providing signal source directly into the ear, they alleviate the problem of understanding speech which is so common among hearing impaired elderly. The systems permit those hearing impaired persons who can still benefit from amplification to raise the level of their participation in many areas of life now denied them, e.g., churches, meeting halls, theaters, courthouses, etc.

There are other similar systems available which were not utilized at the Mini-conference. The point is that there is in existence adequate technology to improve significantly the functional ability of large numbers of elderly hearing impaired people. This technology must be examined and the system most suited to each particular circumstance utilized so that hearing impaired people have the communications access they require in as many life activities as possible.

(2) Systems which are portable, wireless, and require no modification of the environment

A fourth system with which the Mini-conference site was equipped was Phonic Ear, a free-field FM radio broadcast system which can be used with or without a hearing aid. This, too, would qualify easily for what ANSI describes as acceptable communications access.

Research and development projects from the Veterans Administration Medical Center in Birmingham, Alabama, were examined. Clearly, there are in existence many technical devices which can help hearing impaired people in a variety of circumstances and who have differing degrees and types of hearing loss. What works for one person may not always work for another, but creative use of existing technology can identify its limits and indicate needs for new research.

Several delegates stressed the need for innovative use of technology. In so doing, they rejected the thesis of current market strategy in the hearing aid industry, i.e., that the smaller the instrument the better it can be hidden, thus catering to a perceived desire of actual and potential hearing aid users. If a person who can still benefit from amplification is willing to utilize what is available, he need not be bound by the constraints of the hearing aid industry.

Ongoing efforts to ensure telephone compatability with hearing aids throughout the United States were strongly endorsed and encouraged. Although efforts toward this goal have been made over the last four years, we have neither complete compatability nor legislation designed to bring it about.

We stressed appreciation for and greater use of teletypewriters and other telecommunications devices for the deaf (TTYs and TDDs). Installation of these devices in areas of public business of all types (airports, train stations, government offices, etc.) is very effective communications access for hearing impaired people, but is not sufficiently utilized.

b) Special needs of the deaf

(1) Items in the environment

For many hearing impaired people, amplification is no answer at all. They need visual counterparts to sound. In airports, in public buildings, in the marketplace, and even in dwellings (buildings with intercom systems for admission), people who are deaf are disadvantaged. Signs, flashing lights, interpreter service--these are essential to communications access for deaf people. In addition to TTYs, communities might provide answering or relay services for deaf persons. Visual counterparts to public address systems, signs showing subway stations, fares, and schedules in visual format--all would increase the deaf person's ability to cope independently in the daily routine of life. In places where electronic systems are used to provide information, scripts of such narratives should be available and/or interpreters used so that deaf people can have equal access to the data. In short, environments must be examined with attention to enhancing communications access for those who can not hear sound or understand speech.

When we speak of visual counterparts to sound communications, we must note the fact that many older hearing impaired persons also have poor vision. This is an area for deeper examination in terms of the total impact of sensory defects. Things like captioning may be presumed to bring relief to older hearing impaired persons only to find that the captions cannot be read. However, there are millions of people with low vision whose sight can be corrected with properly fitted glasses. The point is, both the hearing loss and the problem of low vision must be addressed in tandem, particularly among the elderly.

2. Arts, Continuing Education, and Spiritual Well-being

Many people who lose their hearing in later life are slow in making the adjustments needed to remain in their normal activities. For those who enjoy theater, several of the amplification systems described herein are enough to permit them to follow the program. A number of theaters are using such systems. A few theaters have regularly scheduled performances that are interpreted in sign language. This activity should be publicized and broadened to fuller use. Another assistive method to help the hearing impaired enjoy theater is to arrange prior review of the script. This is being done in New York.

Many delegates raised the problem of inadequacy of speech-reading teachers. They found organizations were responsive to requests for speech-reading training, but teachers were unavailable. This should be studied and rectified. Sign language classes are often filled with hearing people learning a new skill. In some cases, hearing impaired people were not able to participate because the rate of training would have to be slowed. This should be rectified.

Public Law 504 requires that every public institution be barrier-free. Just as Public Law 94-142 specifies that children have access to an education in their least restrictive environment, so should adults have equal access under law. A hearing impaired adult attending a school or university that receives public support has the right to communications access permitting him or her to function in that environment.

Churches and other places of public and private worship can greatly enhance the ability of hearing impaired people to participate by providing communications access. In many cases, use of sign language in services can provide a dimension of beauty that enhances the celebration and adds to the joy of all participants. Amplification systems are being used, but there seems to be no widespread awareness of the problem or of the means to alleviate it.

D. Health Maintenance and Health Promotion

1. Self-help Groups

There was strong expression for the need for hearing impaired people to take the lead in helping themselves. The development of strong national and local self-help groups was urged. Involvement of hearing impaired people in the attempt to help others admit their deafness, overcome the shock of hearing loss, and lead constructive and rewarding lives was stressed.

Many organizations already exist which would be responsive to specific requests from self-help groups for such things as meeting places, collecting and recycling hearing aids, and participation in community activities designed to inform the public about problems of hearing loss.

It was recognized that the ultimate in communications is interpersonal relationship. Since this takes place on the local level, small groups with individuals helping one another to adjust, to cope with their situation, are essential. Such groups could have whatever technology is needed to assist their members to participate. They could study other modes of communication (sign language, speech reading, cued speech) as desired. They could advance their communities' awareness and pursue projects of communications access for all hearing impaired people.

The number of persons who are hearing impaired is very large (16.2 million). By working together, they constitute a potentially strong power base from which to participate in the political life of America.

As consumers, they must assert themselves. They should insist on membership in any public group discussing issues which affect them. They should participate in development of priorities for hearing health research, for design of changes in the hearing health delivery system, etc. And they must hold accountable for the quality and cost of services and products, all those in the hearing health delivery system.

2. Means for Support and Reinforcement

Informal support structures--family, friends, social, religious, and other affiliations--should be included in this effort. Work on a two-way street should include the older hearing impaired person as giver and receiver of benefits. This would develop the older person as a resource. Involvement of this sort can be rewarding.

a) Different living arrangements

If the living environment supports the capability and meets the needs of the older person involved, it is likely that that person will have a better quality of life for a longer period of time. While older people tend to have a number of problems associated with age, familial and social interactions can facilitate adjustment. It is precisely those healthy relationships which often are most affected by hearing loss.

(1) Living with family or friends

Wherever possible, we want to keep people out of institutions; 95% of older people in the U.S. are probably capable of living alone despite some degree of physical dependency. We can make it easier. About 80% have some chronic condition, like hearing impairment.

By living with family or friends, the older person who is hearing impaired reduces the special threats to safety assumed by living alone. But the increased tension caused by hearing loss can be painful to all members of the household.

Discussion of home health care and independent living affected considerations of cost, awareness, and safety factors, with the realization that older people who are hearing impaired require greater assistance of a community and voluntary nature.

(2) Living alone

In these circumstances, both deaf and hard of hearing people are disadvantaged. Although there are a variety of safety and convenience signal devices, it is costly to live alone if you are hearing impaired. And, in many cases, information on what is available is scant. The result is that many hearing impaired persons living alone suffer unnecessary strain in both communication and reception of data from all sources. Lifeline system devices can be effective for emergency purposes. Other means of emergency communication are needed.

b) Organization of services for older people

Senior centers should be encouraged to develop programs that accommodate older hearing impaired people, to provide appropriate communications access for them, and to utilize their talents in senior center activities. More outreach was encouraged. Coordination with other local organizations to develop community awareness of hearing impairment and its complications was stressed.

(1) Formal and informal support structures

Formal support structures (professionals, organizations, and government) have been asked to play an increasingly large role in the health delivery systems in America. But informal support structures, family and friends, will probably lead in reaching out to elderly people who are hearing impaired. They are more likely to provide an environment of love and security for the older person. They can seek other areas of support when their capacity to deal with a problem is exceeded. But, they are there!

Obviously, the two types of support should reinforce and complement each other. One way of doing this is to develop voluntary organizations which better educate individuals in them, maintain good links with professionals and community resources, and develop advocacy regarding the older hearing impaired person.

But it is important to retain the informal aspects of support that brought the group together. Formalization risks loss of the peculiar characteristics from which it derives strength, i.e., the development of a loving/caring, personalized approach which is rooted in concern for the individual's dignity and self-respect.

3. Quality and Availability of Information and Public Education

Delegates to the Mini-conference came from all over America (25 states) and represented a variety of academic disciplines, occupations, organizations, and different parts of state and federal government. A few were very well informed about the subject matter and items displayed. But, for most, the conference's content and technology were eye-openers.

It was evident that hard of hearing people were much less informed than deaf poople on subjects of vital interest to them. There exist certain organized support structures and dissemination channels used by the deaf. There is also a great deal of information in the public domain if one knows where to go for it. By and large, hard of hearing people do not yet know how to use the system.

Having said that, there is the formidable task of pulling together, in one central repository, details on what is available to help hearing impaired people, where and how it can be obtained, how to use it (with advantages and disadvantages explained), and how much it costs.

There was strong demand for a central nationwide resource center or agency that could identify needs and inform hearing impaired people about available resources to serve such needs--one place an interested person could plug into whether he be a hearing impaired person, a service provider, a researcher, or a friend wanting to help an older person in need.

A catalog or consumers' guide of some sort was repeatedly mentioned as one means of gathering together what is available, how to use it, where to find it, and what to pay for it.

Local centers put together by community resources might serve a similar purpose, with the added advantage of personal attention and demonstration of the items to be used.

Perhaps a nationwide public education campaign could be planned, directed at the following groups:
- a) hearing impaired people over 65
- b) service providers in the hearing health delivery system
- c) informal support structures (family, friends, social, religious, and other affiliations)

It is recognized that a too broadly designed program of public information might flounder on the shoal of inadequate resources. Therefore, we should attempt to work on the target areas either singly or through different sources.

IV. RECOMMENDATIONS

Although priorities were not drawn up, the frequency with which certain subjects were raised clearly established them as areas of major concern. They were:

- PUBLIC AWARENESS/EDUCATION/INFORMATION
- COMMUNICATIONS ACCESS
- HEARING HEALTH CARE COSTS
- DEVELOPMENT OF SELF-HELP ORGANIZATIONS
- RESEARCH
- TRAINING
- HEALTH-RELATED INSTITUTIONS

A. Public Awareness/Education/Information

- The Secretary for Health and Human Services (HHS) should direct the appropriate office to develop plans for a National Public Education Program for hearing health care. Such plan should be drawn up in collaboration with appropriate agencies in the public and private sectors including the use of consumer groups and public television.
- Encourage utilization of captioned TV on public television for purposes of education and provision of information to hearing impaired people.
- Designate one agency to address the problems of older hearing impaired people, to refer them to all sources of assistance, to respond to individual concerns, and to offer support systems.
- Maximize the use of existing telecommunications systems to meet the rehabilitation service needs of hearing impaired people in all areas of the country.
- Publish a catalog of assistive devices or hearing impaired consumers' guide to what is available, where to find it, what it costs, and how it is used.
- Develop and conduct awareness programs for service providers and hearing impaired consumers regarding availability of devices, methods, and related communications information.
- Coordinate organizations at the local and state level (area agencies on aging, service clubs, libraries, etc.) in the development of audio and visual centers for information and demonstration purposes.

- Hold periodic regional conferences on hearing impairment.

B. Communications Access

- Communications access must be provided at local, state, and national levels for hearing impaired people. This includes:

1) Rewording of the communications standard (by the American National Standards Institute) to include a variety of existing sound systems as "acceptable communications access";

2) Implementing the communications access concept as vigorously and broadly as the physical access concept;

3) Amplified phones and TTYs in public areas;

4) Mandated compatability between hearing aids and telephones throughout the U.S.;

5) Expanded utilization of manual and oral interpreters;

6) Increased training of manual and oral interpreters as well as increased training of teachers of sign language, speech reading, and cued speech;

7) Development of TTY call placement systems;

8) Utilization of visual aids in public areas.

C. Hearing Health Care Costs

- The Secretary of Health and Human Services (HHS) should study the desirability and cost impact of coverage of comprehensive hearing health services to include purchase of hearing aids under Medicare. Study should include feasibility of reducing costs and should examine alternative purchasing systems.
- Develop further the 30-day trial use of hearing aids.
- Investigate tax incentives designed to assist innovative technological efforts that benefit hearing impaired people.
- Encourage innovation and creative use of technology in hearing health care. Investigate and include innovative designs for amplification, sound systems, and devices other than hearing aids.
- Develop local core services to serve the needs of hearing impaired people as well as other types of disability.

D. Development of Self-help Organizations

- National and local self-help groups as a concept should be encouraged.

- Consumers should be involved in public and private aspects of hearing health care.
- Organizations for the deaf and hard of hearing should form a coalition to work toward a unified power base that can represent all hearing impaired people.
- Develop an acceptable symbol for hard of hearing people. (Deaf people have an agreed-upon international symbol.)
- Hearing impaired people must take the lead in solving their problems.

E. Research

Public and private research should be conducted in the following areas:

- Genetics of hearing loss among older people
- Expanded investigation of the inner ear
- Noise-induced hearing loss
- Relationship between hearing loss, isolation, and the onset of terminal disease
- Relationship between noise, stress, violence in the setting of multi-generational families
- Improved hearing aids--better quality for less money
- Technological services other than hearing aids

Principal public organizations would be the National Institutes of Health (both the National Institute for Neurological Communicative Disorders and Stroke--NINCDS, and the National Institute on Aging--NIA), the National Institute for Handicapped Research, and the National Institute for Occupational Safety and Health. All four organizations should consider the number of people affected, the enormous cost to society from this persistent and chronic impairment, and the comparative lack of attention heretofore given to the problem, and should move research on the above subjects into their top priority category.

F. Training

- Ensure that all staff personnel at health-related institutions are trained in the condition and problems of hearing loss as it affects the elderly person.
- Develop empathy programs for service providers, family, and federal policy-makers to sensitize them to realities of the hearing impaired elderly.

- Expand curricula at institutions where professionals involved in delivery of health services are educated, to include problems and needs of elderly hearing impaired people:

  1) The American Medical Association, the American Nursing Association, etc., should sponsor such curricula changes;

  2) One-day workshops to sensitize existing practitioners should be held in conjunction with local groups of hearing impaired consumers around the U.S.

G. Health-related Institutions

- Develop hearing health screening programs for anyone over 55 years of age entering a hospital, nursing home, or other health-related institution.
- Require sound and visual systems suitable to effective communication with hearing impaired people in hospitals, nursing homes, and other health-related institutions.
- Enforce regulations for inspection and certification of health-related institutions for communications and physical accessibility.
- Ensure that chronically ill people have every possibility of communicating with essential personnel.
- Encourage the use of auditory amplification devices in physicians' offices to enhance and ensure communication.
- Encourage recognition that a number of older persons who are hearing impaired and who appear unable to manage their affairs may be suffering from treatable conditions rather than irreversible deteriorations, i.e., medical and/or psychological counseling is needed rather than institutionalization.

These recommendations will be refined and sharpened in the coming months at state and regional levels. Hearing impaired delegates to the National White House Conference will be armed with experience and specific means of carrying out the recommendations made herein. The enormity of the work to be done was well understood by participants in the Mini-conference. We must now communicate that to others.

The problem of hearing loss has been periodically and partially examined. But it is clear that in 1981 the need remains to pursue a comprehensive and vigorous attack on hearing loss and its consequences among older Americans.

The spirit of the Mini-conference was clearly one of a new awareness and development toward self help. But while we try to help ourselves, we look to the government to rectify existing inequities of access and cost, and inadequate public information in the field of hearing loss. Although we cannot overcome our disabilities, together we can overcome their handicapping effects.

Respectfully submitted,

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Mini-Conferences have been recognized by the 1981 White House Conference on Aging and convened by organizations that wished to focus attention on special aging issues.

Recommendations of mini-conferences are not the recommendations of the official delegates to the Conference or the U.S. Department of Health and Human Services. They represent the views of the participants in the mini-conferences. They are being made available to the delegates as part of their background materials for the national conference.

The following Mini-Conference Reports have been published:

Recreation, Leisure and Physical Fitness
Aging and Alcoholism
Energy Equity and the Elderly
Public/Voluntary Collaboration: A Partnership in contributing to independent living for the aging
National Health Security
Concerns of Low-Income Elderly
Vision and Aging
Alzheimer's Disease
Arts, the Humanities and the Older Americans
Older Women
Life-Long Learning for Self-Sufficiency
The Urban Elderly
Rural Aging
Long-Term Care
Non/Services Approaches to Problems of the Aged
Spiritual and Ethical Value System Concerns
Transportation for the Aging
American Indian/Alaskan Native Elderly
Pacific/Asian Elderly "Pacific/Asians: The Widsom of Age"
Environment and Older Americans
Rights of the Institutionalized Elderly and the Role of the Volunteer
Veterans
Mental Health of Older Americans
Saving for Retirement
Hispanic Aging
Challenging Age Stereotypes in the Media
Oral Health Care Needs of the Elderly
Housing for the Elderly
Consumer Problems of Older Americans
Senior Centers
Elderly Hearing Impaired People
Black Aged
Legal Services for the Elderly
Simplifying Administrative Procedures and Regulations in Programs Affecting the Elderly
Intergenerational Cooperation and Exchange
Self-Help and Senior Advocacy
Euro-American Elderly
Inter-relationship of Government, Private Foundations, Corporate Grant-Makers and Unions
"The National Dialogue for the Business Sector"
Foot Health and Aging
Pacific Islanders Jurisdiction
Gerontological Nursing

the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on
Challenging Age Stereotypes in the Media

MCR-9

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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Media

"Challenging Age Stereotypes in the Media" was the theme of a conference held on January 15 and 16 at The Interchurch Center in New York, N.Y. with funding from the National Administration on Aging. This was one of a number of preliminary conferences designated to survey current problems on aging and make recommendations to the 1981 White House Conference on Aging. It was sponsored by the Gray Panthers and directed by the Media Watch Task Force of this national organization.

The sponsors believe that this was the first working conference ever held in which media experts and anti-ageism activists joined for the express purpose of planning for improvement in the quality and quantity of older people's representation in all aspects of media operation. It is also unique in that many other monitoring groups have raised issues that we believe this conference was the first to respond to. It is the culmination of eight years of intensive work and exploration by the Media Watch Task Force.

Professionals from radio, television, film, newspapers, books, and magazines led a total of nine workshops in which resource panelists and participants were from their own ranks; from Gray Panthers and other advocacy organizations for older people; and from grassroots groups with a special interest in media coverage of elderly people. The workshops had as their goals: 1) Increasing awareness of how older people are stereotyped in the media. 2) Identifying opportunities for enhancing the image of older people in the media. 3) Developing action plans and strategies to extend the media options of older people; and 4) Planning the establishment of a media center to further the work of the conference.

Within this report "ageism" is used to mean discrimination against a person or group because of chronological age. A "stereotype" is used to mean "an over-simplification or generalization of the characteristics or image of any group that results in the demeaning or ridiculing of that group."

Workshops held on January 15 were issue-oriented, i.e., the subject of ageism was covered as it exists within given areas, along with opportunities to reduce or eliminate it. The special problems of each area were explored as they relate to age stereotyping and, where feasible, resolutions were passed for appropriate action to combat it. In the case of Cable TV: Future Visions there was emphasis on future opportunities, since it is expected that this branch of the media will have a tremendous growth because of advances in telecommunications technology and a changed regulatory climate. Resolutions were aimed at using those opportunities.

In the workshop entitled Innovation: New Program Ideas clips showing recent works with older people as their subjects were the springboard for discussion of how to portray them and change the attitudes toward them, and how to increase older people's access to production capabilities, but it was agreed that at present the dissemination of information about film and tape production is perhaps the most important educational work.

In other issue workshops--Commercials: Bane or Blessing; Print Media: The Potential; and Discrimination in Media Employment--stereotypes and discriminatory patterns of behavior which might be changed through concerted action were recounted, and resolutions made for consideration by the conference and the National Administration on Aging. Examples of new and improved content in the various media branches being discussed (radio, television, and print) were also given.

Workshops held on January 16 were action-oriented, the aim being to show what can be effective in making changes in the media, and how and by whom it can be carried on.

Basic to plans for continuing efforts to combat ageism, it was agreed, is the establishment of a media center to do research, disseminate information, initiate and work with groups engaged in monitoring media, and develop a cadre of people to train older people in all phases of media work. Without such a center such work is likely to be disorganized or lost.

The workshops were designed to provide new information, to generate discussion, to make a report which could be shared and, where possible, to develop recommendations. Summaries of all workshops are included as part of this report. Their resolutions are given with the approval of the conference as a whole, having been reported to general sessions held on both days.

Attached to this report is a program of the conference; a list of the participants in the conference; the Issue Papers which were prepared in advance of the conference and given to all participants, with the recommendation that everyone attending a workshop read the pertinent paper in order to become familiar with the material to be presented; and other relevant material prepared by workshop leaders, including an extensive bibliography contained in the paper "Stereotyping of the Elderly in the Mass Media", prepared by Kathleen Jamieson of the University of Maryland.

It has been particularly gratifying to us that the conference was declared a success by many of the 166 people who attended inasmuch as it was planned and conducted within a period of less than two and a half months, which included three major holiday weekends. This achievement was possible only because of the dedicated efforts of the Media Watch Task Force and particularly that of Lydia Bragger, whose recognized stature, frequant appearances in behalf of an enhanced image of older people, and substantive body of work on standards and guidelines for media use over the past eight years made it possible to enlist outstanding leaders and participants from across the country. One of the principal benefits of the conference, we were told, was the interchange of ideas between people from different parts of the country, as well as between media representatives and well-motivated amateurs in workshops, general sessions, and informal gatherings throughout the two days.

We have already learned that in Albany a radio program is in process of being developed directly as a result of participation in one of the workshops. We have also learned that monitoring activities with criteria developed by the Media Watch Task Force are being started by several Gray Panther networks. Numerous requests have been received for copies of this report which, along with the packet of materials given to all participants, and the planned media center will, we believe, give encouragement and direction to future efforts to influence media--to the end of bettering the self-image of older people, increasing their effectiveness, and to altering fundamentally the images of older people given to children.

We are mindful of the fact that the image of older people portrayed in the media has improved; that several programs have depicted older people realistically and with sensitivity; that radio programs by and for the elderly segment of the population are produced in many localities; that excellent books and articles have appeared about the growing numbers and higher percentage of people past 65 within the nation and their changing interests and needs.

We are increasingly aware, however, that the impact of the media on an ever-widening audience is not fully understood. We can only gain by increasing our knowledge and understanding of it. Within the lifetime of most participants in the conference the broadcast media has been born and become so ubiquitous as to have changed the nature of our political processes and the way in which many children receive their first impressions of the personalities of older people. We have come to suspect that it has given force to a tendency in society to segregate or exclude older people from the mainstream, to relegate them to inferior positions, or to ignore them. As people making up a large part of the audience it is incumbent on older people to see that their image is not distorted, that their roles are not degraded, that they hold the media accountable for less-than-wholesome portrayals. As Lydia Bragger has said, "Since the media influences the way people think, the media must be held responsible for the way it portrays older people."

Many participants in the conference were outspoken about their concern for the most widespread and insidious discrimination of all -- exclusion from the ranks of performers, newscasters, writers and other creative workers, producers, high level technicians, policy-makers. Although 11 percent of the population is over age 65, recent statistics show that less than 5 percent of the characters on prime television are of that age. Mandatory retirement (the issue around which Gray Panthers originally organized) has long been prevalent in journalistic and broadcast enterprizes. With some notable exceptions, people on news programs lack the experience and informed background of people with a long record of reliability. Young, rather that middle-aged or old, people are used almost exclusively to sell products in commercials, where older men appear occasionally but older women hardly at all. The message is one of indifference, even contempt, and it has never made the way easier for older people to lead lives of dignity, with assurance of self-worth. It has, perhaps, enabled a materialistic society to use older people badly.

The Gray Panthers believe, with Ralph Nader, that ". . what information and ideas people receive and when they receive them is the nourishment for enlightened and participatory societies . . citizens need no longer be passive recipients of what a few large corporations choose to beam to them . . rather they can become part of the communications process. ."

As Gray Panthers we are encouraged by our positive accomplishments of the past. We have written and spoken often against age stereotypes in the media. We have contributed to small and large changes. We point to our success in the modification of the National Association of Broadcasters Television Code by adding the word age to Title IV, paragraph 7, regarding special programs, where it was formerly stated that only race, sex, and creed are to be treated with sensitivity. It is a step on which we can build, from which we can move forward with confidence and the knowledge that we have much support.

A special word of thanks should be included in this report for the excellent support and encouragement we have received from Maggie Kuhn, founder and national convener of the Gray Panthers; Richard H. Davis, our keynote speaker and panel leader; Hugh Downs, who took time out from his very busy schedule to be with us, because he cares; our dedicated workshop leaders and resource persons; and our Media Watch Task Force -- Bradford Chambers, Roberta Pikser, Phyllis Sanders, and Loretta Wavra -- who guided us every inch of the way.

A very special word of gratitude is due to Jerome Waldie, former Executive Director of the White House Conference on Aging, for his assistance in making our conference possible.

Workshop Title: Designing an Ongoing Media Center

Leader: Dr. Richard H. Davis, author of Television and the Aging Audience, and keynote speaker of the Mini Media Conference

Resource Panelists:
  Lydia Bragger, Chairperson, Media Watch Task Force
  Eva Skinner, Media Consultant, Gray Panther
  Jules Power, Producer, Over Easy, Educational Television

This workshop, held on the second day of the conference and attended by people who had taken part in two workshops and three general sessions of the conference previously, gathered together ideas and suggestions which had grown out of previous discussions and the materials of the conference. Its attendance was larger than that of any but the general sessions. There was much enthusiam for continuing with the work of the conference by the workshop participants.

The principal goal of a media center should be to educate: To educate the media to present positive and realistic images and combat stereotyping of older people. To educate older people in order to improve their self-images. To educate children in order to give them a positive view of the aging process and older people.

A media center should be properly funded to undertake its tasks, and experienced media consultants should not give their services free.

Sources for possible funding which were mentioned were large labor unions (which often have a program for retired employees); the private sector; the media industry itself. Large private corporations might be interested in a media center to help educate employees near retirement age. These possibilities and others that come to our attention will be explored in the future. We welcome any suggestions from the 1981 White House Conference on Aging.

New York, as a communications center, is the obvious choice as a location. Advisory counsel is available from all branches of the media. Lydia Bragger has for eight years been the leader and recognized voice of a group which will be the nucleus for a center. Her commitment is indispensable.

In radio Gray Panthers have their own program ("Bread and Roses") on WBAI, with time available weekly. A program on Channel L (cable TV) is being contemplated. With these resources, and with the interest generated in the conference, and with adequate funding, we can play to our strengths by:

1. Establishing a media monitoring program, based on criteria already prepared and in use. The radio and cable program and other sources can be used to enlist volunteers from senior citizen's centers and other groups throughout the city for a local monitoring system.

2. Using this as a base to reach out to Gray Panthers and other activists throughout the East to initiate a network of monitoring closely in touch with the center.

3. Doing research based on data obtained in the monitoring.

4. Building up a library of tapes, films, and scripts, as well as a selection of books, articles, and bibliographies in the field of aging and the media.

5. Training older people to produce their own radio programs.

6. Exchanging information with the Los Angeles Media Center so that we complement rather than duplicate each other's work.

7. Publishing a monthly newsletter dealing with timely and critical issues relating to ageism as well as sexism and racism, to include evaluations of current programs and practices in the media and, through circulation to key media people, to alert them to matters of current concern to us, such as the recent backlash suffered by both Blacks and women as reflected in films, television series and commercials.

8. Becoming actively involved with other groups which share some of our views. An instance of a successful alliance is the San Francisco Gray Panthers working with Women Against Rape and Violence to fight against ageism in some popular songs. They have been very successful in their efforts. Pooling resources with such activist groups is highly desirable.

9. Finding alternative sources for education against ageism. Instead of concentrating on The New York Times, organize a letter writing campaign to suburban and smaller city newspapers and broadcast stations. Seek to institute a newspaper or magazine column on aging. Provide samples of such a column. Offer the services of senior writers available for this purpose.

10. Establishing a close working relationship with agencies and groups which have educational programs on aging such as the New York City Department of Aging, and furnish material for their publications. Others are the Jewish Association for Service to the Aged (JASA) and the Junior League of New York. Strengthen contacts with the National Council of Churches and the United Methodist Women, who do educational work nationally. The former have programs in the media and the latter work in the area of improving children's concepts of aging.

11. Enlarging the advisory board of the Media Watch Task Force to include people with experience in all phases of media operations, in organizing, and in fund raising, many of whom are now known to us.

Workshop Title: Cable TV: Future Visions

Leader: Dena Anderson, Professor, Graduate School of Social Work, San Diego State University; Producer/Host, cable TV program; Gray Panther

Resource Panelists:
Ann Sheehan, Program Director, Berks Community TV, Reading, Pa.
John Sandifer, Producer, Channel L Working Group, NYC
Jennifer Stearns, Producer, Office of Communications, United Church of Christ, NYC

Although the promise of cable TV as a community service mechanism has yet to be realized, it was reiterated in this workshop that this can be a medium to carry our messages, our images, arguments, and questions, a medium for self-help. It can help to promote a sense of community which is often lacking in the lives of older people.

A brief account of the growth of cable TV and its physical plant and facilities served to open the workshop. Dena Anderson related her three-year experience working with older and younger people in the PACE Cable television program in San Diego, writing, producing and broadcasting, and she provided valuable information on how to work in this medium.

Reference was made to a booklet written by panelist Sandifer, Cable Television in Communities: A Guide to Community Control and Community Use of Cable Television. Because franchises are involved and these are granted with specifications as to community service in the locality, this medium can be guided by community needs and effectively monitored as to operation. An illustration of a seminal program for and with older citizens was given by panelist Sheehan, Program Director of Berks County Television of Reading, Pa. The Experiment began in 1975 when New York University, Berks TV Cable Company, the City of Reading, and its Senior Citizens Council and the Reading Housing Authority received funding from the National Science Foundation. A two-way cable system was created for complementary groups: the older citizens who make up 16 percent of Reading's large older population, and the public agencies which serve them. A multi-service center and two senior citizens' housing projects were selected as sites for communication centers linked by two-way cable in the initial stages of the experiment. In addition, 117 homes of elderly people were fitted with converters so they could view the cable programs on their home TV sets, and participate by telephone.

The success of BCTV was immediate, and the station quickly decided to carry the programs over a regular cable channel so all subscribers could participate by telephone. The offices of the mayor, city council members, and county commissioners were frequently connected to the system, which allowed citizens to question them directly. Several local high schools and nursing homes were also linked to the system. Most of the production and on-air work was carried on by 7 paid employees, with valuable volunteer work carried on by members of the community, most notably from the older age group. All programs are aired live and later rebroadcast on videotape. Each week a city council member or other public figure is questioned by the public under the auspices of the League of Women Voters.

This emphasis on public affairs has helped BCTV avoid the triviality which has characterized some stations. Program committees meet regularly to direct programming. A corporation was formed after the NSF grant expired, with a governing board and membership representing all segments of the community. Much time must now be devoted to raising funds, and this has altered their programs in some ways. For instance there is now a weekly "Singalong"; there is also a program in oral history. Forty percent of the live broadcasting on this community-minded program is done by older people.

As an offshoot of the work at this station, a former employee has been hired to work on a similar project in Vermont, which will develop a statewide system for telephone communications with developmentally disabled people. As its director has said, "BCTV is a model system."

The work of panelist Sandifer's Channel L group was also discussed. This group has 3½ hours of live programming each Wednesday night. Participants have included elected officials, staff members of government agencies, community boards and non-profit organizations. Typical programs have presented a speaker from one of the city's community boards on the subject of housing for elderly people; another with a local politician on their nutrition requirements; and a city council person updating the fight against mandatory retirement.

Here are some varbatim quotations expressing strong feeling of the participants of this panel: "It is the trend of the future to speak video language; I do not want to be left behind." "The cost of cable service is a major concern to older people." "Older persons should get free cable." "You can't have a community unless you have communication between the people."

Resolutions were passed as follows:

1. To find ways to educate seniors as to cable's existence and availability.

2. To show them, their advocates, and the general public how cable can improve the quality of life.

3. Train people nationally to become "Media Literate", i.e., teach them how to gain access to cable; use it to their advantage; understand the political and community implications of its use; provide technical training for older producers, directors, writers, actors, technicians in all areas.

4. Get financial help for the above.

5. Let the media know what older people want to have changed.

6. Establish networking which is a channel for the exchange of information countrywide on innovative cable systems.

7. In existing franchises, learn what access is granted and use whatever is available.

8. Keep on top of franchises, especially those coming up for renewal, and insist on access if it does not exist.

9. A resource exchange should be established among existing networks providing for an exchange of tapes. Thought should be given to how a media center might use or assist in this exchange.

Workshop Title: Commercials: Bane or Blessing

Leader: Kathleen Jamieson, Professor of Communication Arts,
University of Maryland.

Resource panelists:
Donald Gilbert, President, Specht, Gilbert and Partners, Inc.
Rita Larsen, Gray Panther, Bergen County, N.J.

It was the consensus of this workshop that while noticeable improvement has taken place in the number and role of older persons in commercials there is room for much more, especially older women. Advertisers invariably select younger women to promote products, although age is sometimes considered an asset in men.

Although ageism is rampant, this is an area in which expressions of approval or disapproval will be given thoughtful attention. Advertisers do not intend to produce offensive ads, and objections which are clear and reasonable will help to alter them.

The intergenerational conflict implicit in the use of stereotypes and the absence of older women in energetic, productive roles, was deplored by some participants. The subliminal message is that older women are never good role models, not worthy of being listened to.

Unacceptable advertising cited as examples were: 1) Porcelana Medicated Cream, having been condemned by the Consumer Affairs Committee of Americans for Democratic Action. Their ads are for a cream which they claim will get rid of brown spots on the skin. These are considered very ugly and a telltale sign of age, which is to be avoided at all costs. Age as a threatening word is used often in these ads.

In the ads for Stove Top 15 Minute Stuffing Mix, a young wife is shown asking her husband whether he prefers potatoes or the stuffing, in a subservient way which suggests that her own preferences are unimportant. This is an example of the sexism routinely used in many ads featuring housewives.

Advertising for Charmin Toilet Paper goes to absurd lengths to emphasize the "soft, huggable, squeezable" quality of their product. The women models fondle the toilet paper in a way representing a foolish over-reaction to the product. Women as subnormal humans are by no means rare in commercials.

Positive suggestions which might be made to advertising agencies as put forth by the leader were:

1. Suggest acceptable terms to use in aiming messages toward the desired older market.

2. Avoid the use of "age" as a pejorative word. Focus on benefits of the product which are not stereotypically age-related, i.e., softer, smoother skin rather than younger-looking skin.

3. By casting older people in non-stereotypical roles, withdraw attention from age identification. The age of people shown in appealing roles is not perceived as their salient feature.

Panelist Gilbert reinforced the last point by stating that he believed the goal of advertisers should be to show people 50 and over in such a way as to make age irrelevant. Presenting non-stereotyped characters could achieve this.

As for strategies to use in seeking to upgrade the images used in advertising, he offered the following:

1. Provide solid business reasons for advertisers to include people 50 and older. Available sources provide usage/consumption data, and information on financial status and buying habits which show the importance of the over 50 group to most lines. New techniques available for targeting the audience, such as psychographic profiles which go beyond demographic data, could "blow the age question and stereotypes right out of the water." Gilbert believes that the psychographic profiles sought by advertisers will include a large segment of people over 50, and this will mean a great stride toward ending stereotyping.

2. Send older representatives to corporations and agencies, with relevant information to back up their position. The face-to-face situation increases the impact of the message.

3. Send a complaint to the American Association of Advertising Agencies, which will forward it to the producer agency.

4. Write the network which broadcast the offensive commercial. Your card or letter will be forwarded.

5. As a last resort, boycott the product.

The first approach selected can be extremely effective since it allows the agency to engage in dialogue with the complaining group and decreases the likelihood that the agency will become entrenched in defending an ad campaign.

Workshop Title: Print Media: The Potential

Leader: Bradford Chambers, Director, Council on Interracial
Books for Children

Resource Panelists:
Bayard Hooper, Editorial Director, Prime Time magazine
Christopher Trump, Associate Dean, School of Journalism,
Columbia University

A recurring theme of this workshop was that the oppression of older people in our society is basically economic and cannot be reversed except through evolving economic justice. Awareness of the prevailing stereotypes is not enough. We must analyze their functions and the interrelation of ageism with class, sex, and race discrimination. The workshop took special note of the double oppression of older women and the triple oppression faced by Blacks and other minority women.

Panelist Trump underscored the major difference between the broadcast and print media -- the fact that the latter is not legally bound to devote some of its effort to public service content. The First Amendment, in granting freedom of the press, said nothing about their accountability. This is the source of one problem Gray Panthers face in bringing to the general public their views on stereotyping. It is one reason their efforts have been directed toward the broadcast media; one of the reasons there are separate workshops on these media branches in this conference.

The print media is best suited to extended coverage of broad issues and to in-depth treatment of them. The forte of broadcasting is the coverage of events as they unfold. Many suburban papers go out of their way to publish letters from their readers, and the Op-Ed page featuring reader input is gaining popularity throughout the country. The New York City papers are harder to break into. The Bergen County Record devotes much space to older people's activities and in fact put the announcement of this conference on its front page. Newsday, a Long Island, New York publication, carries a regular column on Older People written by an older person, Lou Cottin. None of the city papers carried advance coverage of this conference, although the New York Times carried a brief report afterwards.

Outside New York a shift toward monopoly ownership and one-newspaper cities has occurred, and newspapers are flourishing and highly profitable there. A beneficial effect of this is that publishers spend more time on issues of social consequence, being free from competition. Some workshop participants expressed incredulity at Trump's analysis of this, and thought it would be useful to have hard data in support of such a premise.

Chambers said that few Americans are aware of the role the print media plays in shaping children's attitudes toward old people. As our society moves increasingly toward age segregation, children sometimes get their first images of older people from the picture books which are given to them while they are still in cribs. Studies published by the Council on Interracial Books for Children show beyond question that children's literature is filled with negative stereotypes about older people.

Panelist Hooper reported success in his venture into the 45 to 65 page group. Mass magazines have usually aimed for an audience 18 to 39 years old. His magazine is on the "slick side", and while participants agreed it might be helpful in assisting affluent people to plan for retirement it was not a model for the kind of print journalism required to fight the oppression of older people.

Trump was optimistic that the trend of the print media's interest in public issues will continue. He urged Gray Panthers to mount a pressure campaign for coverage of ageism and related issues.

Resolutions made in this workshop were to:

1. Join with other activists fighting racism, sexism, and bias about disabled people.

2. Fight ageism in government agencies and private enterprizes concerned with age where management positions are filled by young people. Sufficient effort is not made to seek out older people for management-level positions.

3. Call on the White House Conference to alert the public as to the stereotypes contained in children's books and learning materials and the critical role they play.

4. Make a strong effort to get newspapers and magazines to introduce a regular feature devoted to the concerns of readers 65 and over. Also that we undertake to sensitize reporters and editors to issues of ageism.

5. Make an urgent request that The New York Times undertake investigative reporting on the economic straitjacket in which older people are placed by a) the rapidly rising costs of rent, fuel, food and health care; b) the federal requirement that unemployment benefits be deducted from social security income; and c) the punitive effect of deducting from social security income asserted equivalency payments such as food stamps, medicaid, and subsidized housing. This resolution should be acted on as soon as possible by the Gray Panther Media Center.

6. For newspaper and magazine articles on subjects affecting the lives of older people and ageism issues, we urge that editors make an effort to assign coverage to older writers.

7. A major effort should be made to persuade alternative publications to take over responsibility for covering issues of ageism, since the economics of commercial publishing often preclude it.

Workshop Title: Innovation: New Program Ideas

Leader: Christopher Sarson, Sarson Television Productions, Inc.,
Producer/Director, Educational Television

Resource Panelists:
Lorraine Gray, Producer, Labor Education Film Center, Washington,DC
Donald Schwartz, Producer, Low Sulphur Films, NYC
Jennifer Woolcock, Producer, Low Sulphur Films, NYC

In this workshop the panelists showed clips from new tapes and films to generate discussion of the treatment of older people and "brainstorm" for easing the production of more such products, by and with older people.

Clips from Winslow House, a series about residents of an intergenerational house, were shown, as were clips from Louie, which provoked discussion as to whether ageism was shown within the clip.

Three clips from a film made by the Labor Education Film Center were shown by Lorraine Gray, and another series was shown put together by Winfield Best of Communication Resources Foundation of Chapel Hill, North Carolina in which four young and four old people reach out to each other in an innovative way.

Following are among the ideas which emerged from this Workshop:

1. There are too few programs which deal with older people. New programs should show good role models; tap the wisdom and experience of old people; enable them to speak for themselves in film.

2. Attention should be given to programs showing an interchange of ideas between different generations.

3. Old people should participate more in the creating, production, and presentation of programs about their peers.

4. Access to production facilities should be made practicable for older people. A consortium should be created which could disseminate information and get concerned groups together.

5. The wide distribution of films already made, which combat stereotyping, should be encouraged through any means available.

Workshop Title: Discrimination in Media Employment

Leader: Phyllis Sanders, Commentator, Prime of Your Life, WNBC-TV
Reporter, Producer, Host

Resource Panelists:
Louise Gray, Director, Special Services, United Methodists
Natalie Priest, Chairperson, New York Women's Committee, AFTRA
Frieda Zames, Chair, Access Committee, Disabled in Action (DIA)

The broadcast media is prestigious because it has so much power and money and confers status and authority on those who appear on its screens. Many people who watch a great deal are, in a sense, brainwashed. Employment of older people in television is important because the lack of them says so much. There are few places in this medium where old people can get employment, at either the entry level or other stages, and what we need is their presence in all areas including decision-making. A few programs which do feature older people have a patronizing attitude, or use younger people exclusively as interviewers or hosts. Mention was made of a program recently moved to prime time in which Phyllis Sanders, leader of this workshop, and 60 years old, is a commentator with freedom to choose her subject matter and approach. This is Prime of Your Life, on NBC, which welcomes audience response.

A new movie which treats older characters sensitively, in a realistic life situation, is Tell Me a Riddle, based on the famous short story by Tillie Olsen and produced by a woman.

Panelist Gray voiced her concern over children's views of older people and the stereotypes they believe in because of the books they read and the programs they watch. The work of her organization is to challenge these stereotypes, which can only lead to discriminatory attitudes unless children are taught to become thoughtful readers and watchers, or healthier images are given to them.

Panelist Zames spoke to the problem of employment in the media of disabled people. No group is more discriminated against in the media. All disabled people are pictured as being severly disabled, not as individuals with varying degrees of capability and talent. Fifty percent of the handicapped people who could work are unable to find work. They are not even included in unemployment statistics. Her organization is strongly opposed to programs such as telethons which portray disabled people as helpless and objects of pity.

Both the American Federation of Radio and Television Artists and the Screen Actors Guild monitor the media actively, according to panelist Priest. The 1980 AFTRA report contains the following: "The television information gathered ... shows a landscape of commercials in which women of authority are barely visible and minorities hardly present..." AFTRA's Equal Rights Committee, Women's Division, conducts an Orchids and Onions project to encourage expressions of approval or disapproval of personalities, programs, and opinions in television programs. Participants were urged to write "orchid" or "onion" letters about programs they watch.

Resolutions passed in this workshop were:

1. The public must express dissatisfaction, or applaud programs they enjoy, as part of the communication process; in other words everyone should be an active media monitor.

2. Older people should work in front of the camera and in all levels of work behind the camera, including policy-making jobs.

3. A cadre of persons who can train directors, producers, script writers, etc. should be developed from among the older population, to fill jobs or to create them.

4. We should actively fight mandatory retirement in the media.

5. We should educate the media about the strengths and talents of older people.

Workshop Title: Public Service Announcements: How To Write and Get Them on the Air

Leader: Winnie Gorlin, Assistant to the Vice President, Program Practices, CBS

Resource Panelists:
Benjamin J. Dudley, Communications Director, National Caucus for the Black Aged, Inc.
Sheila Terrace, Director of Community Affairs, ABC TV
Sudie George, Journalist, member of Media Watch Task Force

A professional approach, following strict guidelines and made to the person in authority, must be used in obtaining time for public service announcements on networks or local television stations. The demand for time is great, the legal limits well defined, and detailed background information on the organization requesting it must be provided.

Representatives from CBS and WOR TV furnished to participants booklets to serve as guides in planning to acquire such time, which also contain data on obtaining coverage in editorial or news programs as well as the mechanical requirements of tapes or slides to be used. Examples of announcements carried on networks were mostly from the health field, which led to discussion on the requirement that such material be noncontroversial and any claims made must be substantiated in advance. The booklets can serve as handbooks for any group considering the use of spot announcements.

Panelist Dudley's material prepared for his presentation in the workshop, and included in the packet given to all who attended the conference, was on "Effective Publicity Techniques" and might serve as a guide on how to achieve the professionalism advocates must have throughout the communications field if they publicize their causes well. Although TV spots have more impact, he wrote, they are more expensive and time-consuming to produce, and he recommended concentration on radio. Advance planning and knowledge of the mechanical requirements of stations is necessary in all cases.

Because of time limitations discussion on the different requirements of cable TV as it exists and with its expected expansion, was held to a minimum. Gray Panthers or others hoping to use spot announcements are well advised to consult the materials distributed as a first step toward making use of this important but circumscribed air time. People who direct its use will consider new material if it meets their requirements.

Workshop Title: Radio: How to Have Your Own Program

Leader: Ruth Coley, Broadcaster, Now and Then, Program by and
for the Elderly, Oshkosh, Wisconsin

Resource Panelists:
Ernestine Allred, Broadcaster, WXPN, Philadelphia, PA
Dave Metzger, Producer, WBAI, Pacifica Station, NYC

All panelists conduct their own radio programs and recommend this as a participatory medium of growing importance to the elderly community. The report on Now and Then led off the workshop and is given here as a prototype of other programs discussed:

The University of Wisconsin/Oshkosh Social Work Department together with several county and area committees on aging sponsor Now and Then and funds come from CETA, Green Thumb, Inc., and several private concerns. Members of the staff are all over the age of 55. The one half hour program is broadcast daily, Monday through Friday; at 11 a.m. on WRST and with an entirely different staff on WLFM at 4 p.m. Ruth Coley shares moderating duties on WRST and since the program's inception the Monday and Friday shows have dealt with social security, the Meals on Wheels program, educational opportunities for older adults, medical emergency procedures, alcoholism and aging; sex after sixty, physical fitness, and the Gray Panthers, of which Ms. Coley is an active member. Tuesday and Thursday shows take an historical slant, and guests have an opportunity to discuss their past lives and occupations. Rounding out each program is a five-minute news report and a musical selection. Specific topics to be aired are listed in advance in the Oshkosh Daily Northwestern and the Senior Citizen Calendar in the Appleton Post Crescent.

Coley advocates elderly leadership and involvement in civic, church, and educational affairs. She points out that of the 19,000 seniors in Winnebago County, only about 1,300 require extensive health care. "That leaves 17,700 people like I am" says Ruth, able and willing to contribute to society.

Now and Then is now in its second year and Coley will continue to be the moderator for the Monday, Wednesday and Friday programs. The program was established to 1. Produce comprehensive programming which presents information about aging as it pertains to education, employment, health care, retirement planning, housing, transportation, etc. 2. Increase the number of contacts between service providers and potential consumers. 3. Place realistic role models of older adults in the media. 4. Provide employment opportunities for the elderly.

The people responsible for Now and Then have published a booklet entitled Starting From Scratch which is available through Station WRST, Oshkosh, Wisconsin. It covers procedures and principles on how to have your own radio program.

Although no resolutions were passed in this workshop participants were urged to investigate opportunities in radio in their own localities.

Workshop Title: Monitoring and Media Activism

Leader: Dr. Everett C. Parker, Director, Office of Communications,
United Church of Christ

Resource Panelists:
- Bettye Hoffman, Vice President, Program Information Resources, NBC
- Inge Roberts, Member Media Watch Task Force, Sarasota, Fla.
- Beryle Banfield, President, Council on Interracial Books for Children

Less than two dozen complaints about ageism in programs or commercials were received by NBC in 1980, although over 330,000 cards or letters came in from viewers. Panelist Hoffman has been encouraged by the improvement she has seen in television programs as to their use of non-stereotypes. At NBC the Broadcast Standards Department and their editors monitor for instances of stereotyping. In cases where Lydia Bragger gets in touch with a station to discuss a program -- Speak Up America was an unsavory recent example -- she was invited to screen it with the TV executive in charge and they discuss features which are not acceptable. While the Gray Panther point of view does not always prevail it is always constructive to keep open this line of communication. Gray Panthers and others should educate older viewers as to their responsibility to participate in the communications process.

According to panelist Banfield, the monitoring criteria her organization uses in examining books and learning materials for children concerns characterizations, language, roles, and power relationships. In materials on adults any or all of these aspects can show broad or subtle bias in portraying people. Although in the past bias might have occurred unconsciously, book publishers in particular have beomce very conscious of the work of the Council on Interracial Books for Children, a small but significant organization whose standards for scrutinizing communications material might well be taken over by all active monitors.

Ms. Clarissa Wittenberg of the National Institute of Aging discussed her agency's work in identifying and attempting to eradicate the ageism in medical textbooks, and out-of-date or inaccurate information contained in the pharmacopoeia--a continuing struggle.

The workshop leader reported on efforts to combat discrimination in the networks against older people as well as minorities and the poor because they are thought to lack the means to do "impulse buying". Failure to employ older people and minorities has continued in spite of much protest and litigation.

Media activism can be most effective when carried on by coalitions. A local coalition with clout might consist of churches, synagogues, NOW, Gray Panthers, unions, mental health associations, the PTA, etc. One such coalition is being lead by the United Church of Christ against the Newhouse Company in Birmingham, which has a record of ignoring its public responsibilities.

Parker urged all media activist groups to join the Telecommunications Consumer Coalition, which puts out valuable information on legal issues affecting broadcasting and cable and has recently reported in detail on the Federal Communication Commission's recent decision to deregulate radio. Results of this deregulation will be of vital interest to media-monitoring groups and advocates for the elderly since it might change the amount of time available for public service issues.

No resolutions were passed in this workshop, in part because its work was closely related to the proposed establishment of a media center, where recommendations about monitoring were made. Much enthusiasm was shown by participants for active media-watching in the future.

Report prepared by:

Lydia Bragger
Sylvia Friedman
Sudie George

PARTICIPANTS IN THE CONFERENCE CHALLENGING AGE STEREOTYPES IN THE MEDIA

Clara Allen, New Jersey Division on Women, Newark, N.J.

Ernestine Allred, Broadcaster, WXPN, Philadelphia, Pa.

Helen Alpert, Overseas Press Club, Women Strike for Peace, New York City

Lorraine Altman, Director, Retirees Program, College of New Rochelle, City Campus, New York City

Dena Anderson, Graduate School of Social Work, San Diego State University, Producer/Host, Cable TV Program

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Beryle Banfield, President, Committee on Interracial Books for Children, New York City

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Recommendations of mini-conferences are not the recommendations of the official delegates to the Conference or the U.S. Department of Health and Human Services. They represent the views of the participants in the mini-conferences. They are being made available to the delegates as part of their background materials for the national conference.

The following Mini-Conference Reports have been published:

Recreation, Leisure and Physical Fitness
Aging and Alcoholism
Energy Equity and the Elderly
Public/Voluntary Collaboration: A Partnership in contributing to independent living for the aging
National Health Security
Concerns of Low-Income Elderly
Vision and Aging
Alzheimer's Disease
Arts, the Humanities and the Older Americans
Older Women
Life-Long Learning for Self-Sufficiency
The Urban Elderly
Rural Aging
Long-Term Care
Non/Services Approaches to Problems of the Aged
Spiritual and Ethical Value System Concerns
Transportation for the Aging
American Indian/Alaskan Native Elderly
Pacific/Asian Elderly "Pacific/Asians: The Widsom of Age"
Environment and Older Americans
Rights of the Institutionalized Elderly and the Role of the Volunteer
Veterans
Mental Health of Older Americans
Saving for Retirement
Hispanic Aging
Challenging Age Stereotypes in the Media
Oral Health Care Needs of the Elderly
Housing for the Elderly
Consumer Problems of Older Americans
Senior Centers
Elderly Hearing Impaired People
Black Aged
Legal Services for the Elderly
Simplifying Administrative Procedures and Regulations in Programs Affecting the Elderly
Intergenerational Cooperation and Exchange
Self-Help and Senior Advocacy
Euro-American Elderly
Inter-relationship of Government, Private Foundations, Corporate Grant-Makers and Unions
"The National Dialogue for the Business Sector"
Foot Health and Aging
Pacific Islanders Jurisdiction
Gerontological Nursing

the 1981
White House
Conference
on
Aging

Report of the Mini-Conference on Euro-American Elderly

MCR-10

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

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TO THE DELEGATES

The first White House Miniconference for Euro-American Elderly, held in Baltimore and Cleveland during the fall of 1980, highlighted the situation of elderly who identify themselves as members of any of the culturally diverse groups who make up the mosaic of European Americans. The list of the major recommendations resulting from spirited clarification of the issues affecting the lives of the elderly are presented here for quick reference. A greater elaboration of the background and the context within which the situation of Euro-American elderly may be viewed is provided in the text of this report. The recommendations listed here are organized into three sections: 1) Increasing Ethnic and Cultural Sensitivity in Government Programs; 2) Enhancing Mediating Structures and Neighborhoods; and 3) Strengthening the Family Life.

Increasing Ethnic and Cultural Sensitivity in Government Programs

-- The Euro-American older population should be clearly recognized by all levels of government as an identifiable group in the older population, and one whose various social, spiritual and economic needs and strengths should be taken into consideration in both the programming and policy-making processes of this country.

-- There should be more Euro-American ethnic affairs representation in the Federal Government and these persons should be of Euro-American descent themselves. There should be Euro-American ethnic affairs representation in such key areas of the Executive as the Office of the President, the Office of Management and Budget, the inter-agency coordinating offices, and the major cabinet posts of the Federal Government. There should be much greater representation of persons of Euro-American descent in the judicial system of the nation.

Enhancing Mediating Structures and Neighborhoods

-- Ethnic communities, groups and religious organizations should be given financial and other incentives from government and/or voluntary funding sources to create their own specialized living arrangements, social services, nutrition programs and other group self-help activities.

-- Residents of ethnic communities, especially the elderly and their organizations should be formally involved in all private and public policy decisions involving service and resource allocations affecting their neighborhoods.

Strengthening the Family Life

-- Incentives should be made available to families to assist ongoing care to the elderly by: tax deductions or credits; income supplements or constant attendance allowances, respite or relief services, adult day care; funds to make alterations or additions to existing homes; encouragement of inter-generational and shared housing; and improved Medicare and Medicaid benefits for in-home care.

-- Arts and humanities programs should draw from the diverse cultural heritage of Americans, including those of European heritage, as a means of strengthening family bonds.

-- Where nursing home care is required (as a last, not a first step in caring for elderly family members), eligibility for Medicaid help should be raised to include now non-eligible low-income families (with some co-payment) so that their pauperization is reduced.

Preamble

The first White House Miniconference for Euro-American Elderly represents a major, historically significant event for this long forgotten, long overlooked bloc of the aging population in the United States. These elderly people, numbering close to seven million or over one-quarter of the total population in the country of people who are 65 years old and older,*/ were never before counted, nor were they called upon to send delegates to the previous White House Conferences on Aging. For this generation, use of their ethnic language and the maintenance of their ethnic culture are central factors in well-being. A lack of previous political assertiveness on their part does not correspond to a lack of interest in matters related to their welfare nor to a lack of needs, wishes and expectations concerning the improvements deemed necessary to bring about a wholesome and meaningful life for all elderly Americans, including those of European origin. Rather, it is, perhaps, a result of an instinctive shying away from the limelight, from activism, from self-assertion that characterizes this generation of elderly Euro-Americans. After all, two centuries of assimilationist and melting pot indoctrination has intimidated them and undermined their belief in the legitimacy and value of their ethnic patterns to society.

Studying their use of both the formal (government, public) and informal (family, friends, voluntary associations) support systems available in their ethnic communities and neighborhoods, **/ it became evident that the Euro-American elderly represent much more than a "silent majority" among the major ethnic groups. These same people with their broken English are the ones who, along with all other elderly, have spent a lifetime of effort to make this country strong, affluent and free. These are the people who worked hard to build neighborhoods and cities, and who contributed mightily to the welfare of their families, their ethnic communities, and to society at large. The changes in public policy which have created service bureaucracies and institutionalized new forms of national politics, such as interest group and professional control of allocation, tended to mute the concerns of Euro-American elderly. With the historical opportunity provided them through the convening of the 1981 White House Conference on Aging, it was natural that their concerns, their needs, their strengths, and their worries would find a public forum for open expression.

The idea of convening a special White House Miniconference on Aging for Euro-American elderly, a long cherished dream of the Director of the Center for the Study of Pre-Retirement and Aging of The Catholic University of America in Washington, D.C., was recognized by the President of the National Center for Urban Ethnic Affairs as constituting the best vehicle for enabling elderly Euro-Americans to participate in the mainstream of society -- including the formulation of policies consistent with their aspirations and hopes. Wholeheartedly endorsed by the Executive Director of the White House

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*/ United States Census, "Characteristics of the Population by Ethnic Origin," March, 1971, 1972.

**/ Guttmann, et. al., "Informal and Formal Support Systems and Their Effect on the Lives of the Elderly in Selected Ethnic Groups", Final Report, AOA Grant No. 90-A-1007, January, 1979.

Conference on Aging and fully supported with funds and encouragement by the National Endowment for the Humanities and by ACTION, the dream of the White House Miniconference for Euro-American Elderly has become a reality through the collaboration of The Catholic University of America Center on Aging and the National Center for Urban Ethnic Affairs. Ms. Galina Suziedelis and Mr. Joe Coffey served as co-coordinators of the Miniconference.

In the spring of 1981, a meeting of representatives from all interested national ethnic organizations resulted in the formation of an advisory council to monitor the Miniconference. A two-phase miniconference was agreed upon. The first phase, which occurred November 10-12, 1980, in Baltimore, Maryland, concentrated on the involvement of national ethnic leaders,*/ national leadership in the field of aging and elderly ethnic themselves. The agenda consisted of addresses and workshops given by nationally known experts in the fields of gerontology, ethnicity, informal support systems. A list of issues developed by the Advisory Committee of the White House Conference on Aging was used as a base for discussion with concentration on those areas of special interest to the Euro-American elderly. The results of this phase of the Miniconference were then transmitted to the participants of the second phase, which took place in Cleveland, Ohio on December 4-6, 1980.

The Cleveland phase further refined the recommendations of the Baltimore meeting and the participants included more grassroots leadership and older persons. Each conference involved approximately 200 people with voting delegates consisting of representatives of national ethnic organizations, local ethnic organizations, neighborhood organizations, and individual Euro-American elderly and non-elderly. Non-voting observers to the conference included representatives of national aging organizations, special interest groups, government and individual scholars and experts. It should be noted that this Miniconference was the first opportunity to bring together ethnic elderly and their representatives from many different Euro-American ethnic communities with both government (public and private sectors) who together comprise the "aging network."

The two White House miniconferences on aging of Euro-American elderly were truly a labor of love. Many individuals and organizations have contributed to their success. A listing of the key speakers, presenters, and greeters is provided in the Appendix, along with the various national ethnic organizations who were represented on the advisory council. We wish to thank the White House Conference on Aging staff and the members of the organizing committee (also listed) for their invaluable help and tireless effort on behalf of Euro-American elderly. We hope that the voices of these people will be heard by all the delegates, by the policymakers in the Administration and in the Congress and that together they will shape and ensure a better future for all elderly Americans.

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*/ Dr. Stephen Aiello, Former Special Assistant to President Carter and Director of the White House Office of Ethnic Affairs and Dr. Myron Kuropas, Former Assistant to President Ford were among the speakers in the Miniconferences.

In the following pages we will present not only the results of the two Miniconferences, but also the background discussion of the issues which led to the main recommendations made by the elderly participants.

Background */

For the sake of common understanding, ethnicity is being defined as cultural uniqueness, historically derived. Distinct ethnic groups here in the United States are the result of cultural traditions brought over by the immigrants from their countries of origin. These cultural traditions consist of a shared symbolic system of meanings referring mainly to values and attitudes, but including distinct relational patterns and especially communication patterns (language, both verbal and non-verbal, etc.). There is a common core which maintains a given ethnic cultural identity. There is also the ever-existing factor of changes and modifications of these "transplanted" cultural traditions, due to adjustments and learning in the new socio-cultural environment, which make for deviations from the original patterns -- but sufficient continuities of these patterns always seem to remain to preserve the ethnic identity -- sometimes over many generations. This tenacity of ethnic-cultural identifications in immigrant groups and their descendants has led to the formal acceptance by scholars, religious organizations, governmental bodies and by the United Nations and its subdivisions, of the principle of "the inalienable right" of immigrants and ethnic minorities all over the world to retain and cultivate their cultural traditions, and to transmit them to their oncoming generations.

On the social level, the maintenance of cultural distinctiveness by groups in a larger society leads to the concept of "cultural or ethnic pluralism" which, if fully developed, may result in cultural enrichment of the general society; in heightened sensitivity in human relations enabling conscious coping with relational problems and, in strengthening of unity through diversity.

A nation of immigrants, the United States of America has absorbed well over 50 million newcomers from all corners of the world, comprising over 100 ethnic groups, about 50 of them major groups. **/ The main influx of immigrants occurred in two periods: the first, also called the "Old Immigration", deriving mainly from Northwestern Europe and lasting from about the 1830's to the 1880's -- involved over 18 million immigrants, and the second, called the "New Immigration", lasting from the 1880's until World War I, i.e., 1914, involved over 23 million immigrants mainly from East and South Europe.

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*/ We are indebted to Dr. Richard Kolm, Adjunct Professor at The Catholic University of America for the materials used in this section of the report, which were taken from "Issues of Euro-American Elderly in the 80's", A paper presented at the White House Miniconference For Euro-American Elderly, November 10, 1980, Baltimore, Maryland.

**/ President's Commission on Mental Health, 1978.

The main factor in the absorption of newcomers during the "Old Immigration" period was the agrarian lifestyle leading to their dispersion on the widely scattered farms and their consequent rapid assimilation. Later, the territorial expansions and the movement westward to populate the empty spaces of the vast land favored similar absorption processes for those who followed.

Parallel to these assimilationist tendencies, practices of discrimination and of group prejudice also developed, largely attributable to the colonial heritage, as derived from the typical and usual attitudes of superiority of the colonial masters first toward the native Indians, then extending to the black slaves and the indentured servants, the Catholic Irish and Catholics in general, the East and South Europeans, the Hispanics, the Latin-Americans, etc. The dichotomization of the American society into the white and non-white was also derived from these attitudes of superiority of the initially dominant group over others.

The assimilation period ended when rapid industrialization caused large numbers of culturally diverse immigrants from East and South Europe to concentrate in urban industrial centers, thus rendering inoperable the assimilationist social philosophy based on agrarian lifestyle and the dispersion of immigrants. A new concept, that of the "melting pot" theory was introduced, based on the idea of American society as a blending of all racial and cultural elements into a new type of human being, superior to all ingredients of the blend. It gave the diverse ethnic elements an illusion of equality, and provided a nearly religious hope for a universal solution, not only to the dominant groups but also to the ethnic minorities themselves.

The popularity of the melting pot ideology in the post-World War II period was unquestioned. Social scientists, the media, the bureaucratic establishments on all levels, simply dropped the subject of white ethnic diversity. Non-white minorities were never included in the melting pot idea and consequently could not be assimilated and were not even generally recognized as part of American society. Thus the term "ethnic" became at some point identified with white minorities only.

The lack of inclusion of non-white groups in the melting pot concept exploded in massive protestations and confrontations in the 60's which led to Black awareness. The white ethnic groups and especially the East and South Europeans also became aware of their suppressed status in society -- a suppression which was not only cultural, but also social and economic.*/ Their hopes for social and economic improvement had not materialized. The melting pot had failed them and they began to turn once again to their national groups for security and comfort.

As research has shown, the time of arrival of immigrants to the United States and the attitude of society at that time toward newcomers is an important variant in the adjustment of immigrants in general and, consequently, also in the outlook of ethnic elderly. The present Euro-American elderly, and especially those of East and South European origin, came not only from different culture but even if from the same cultures, they came by waves at different times.

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*/ Guttmann, et. al., 1979.

These waves, sometimes generations apart, left their country at different historical periods, thus having often radically different experiences of being raised under the rule of foreign powers or in periods of their country's independence and freedom.

In some groups, like the Polish, Slovak, Hungarian, and others, there still exist some elderly who arrived in the United States before or shortly after World War I, although most of their elderly were born in the United States. There are also in these ethnic groups elderly who belong to the post-World War II immigration. In some ethnic groups, such as the Estonian or Latvian, most or even all of the elderly are recent post-World War II immigrants. That these elderly would have different problems -- social, cultural and emotional -- from those that arrived two generations earlier is easily understood. It can also be expected that most of the later arrivals may still have some language problems and consequently may avoid contacts with the general community and its service agencies.

The overriding factors, however, remains the cultural factor. Although aging is obviously a universal human phenomenon and the ethnic elderly are in their basic problems, needs, and concerns like all other elderly, aging is also a cultural phenomenon with each cultural group having developed over centuries their own unique patterns of aging, of coping with problems of aging, and of taking care of the aged. Involved are values, motivations, relational patterns, and attitudes toward work and leisure time, hobbies, financial security, religion, life satisfaction, illness and death. Significantly, there is not enough information about Euro-American ethnic groups in American society, their similarities and differences in cultural contents and forms and in their ways of adjustment and coping in the American environment.

On the basis of the available research on the Euro-American elderly, and mainly the research conducted by Catholic University on eight Euro-American groups in Washington-Baltimore in 1976-78,*/ the situation of the Euro-American elderly can be summarized as follows: the orientation of these elderly is still largely tradition-bound. The family has still the main and nearly exclusive responsibility for its elderly. In some groups, friends and relatives play an important part in providing informal support to the elderly. There are, however, some serious problems arising from the traditional arrangements as reflected in a felt need by the families, especially those taking care of frail elderly, that some form of external help is necessary. In addition, many elderly do not have families and about 20% of the total population under study had "nobody to turn to in time of crisis."

Moreover, it was found that the Euro-American elderly do not use the available communal and governmental services to the elderly to any significant extent. Some reasons for such underutilization are unawareness of these services, unwillingness to be identified as a recipient of "welfare", insufficient knowledge of English, and insensitivity of agency personnel to the ethnic client.

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*/ Guttmann, et. al., 1979.

The Euro-American elderly are strongly attached to their ethnic culture and the specific ethnic community within which most of their friends reside and most of their social interaction takes place. They are concerned with the preservation of their cultural heritage and identity and feel that they have a responsibility to transmit these to the younger generations. The Euro-American elderly feel that they are better treated in their own communities than the elderly in the general society -- they are treated as part of the adult group and function as such according to their individual interests and capabilities.*/

The full understanding and acceptance by society of the cultural variations in dealing with aging is a basic condition for an effective solution of the problems of the aged and aging in the pluralistic society such as the American society.

Issues and Major Recommendations

Introduction

In both phases of this Miniconference, a total of eleven workshops were given by recognized leaders in their respective fields. These workshops convered the following issue areas:

1) The Family, Social Services and Other Support Systems

2) The Neighborhood as a Means of Fulfillment in Later Years

3) Social, Cultural and Economic Barriers to Full Participation in American Society

4) Long Term Care Needs and Solutions

5) Ethnic Heritage as a Contribution to an Age-Integrated Society

6) Unique Needs and Resources of Elderly Euro-American Women

7) Work and Retirement

8) Role of the Church/Synagogue in the Well-being of Euro-American Elderly

9) Economic Security

10) Health and Nutrition

11) Empowerment and Volunteerism

Each of these workshops produced a set of recommendations. These in turn, were further refined by the participants in the Miniconference. The final set of the major recommendations made by the delegates in both conference phases is presented here. A short description of the main issues pertaining to each of the recommendations is given to highlight the gist of the problem discussed.

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*/ Civil Rights Issues of Euro-Ethnic Americans In the United States: Opportunities and Challenges, A Consultation Sponsored by the U.S. Commission on Civil Rights, Chicago, Illinois, December 3, 1979

Increasing Ethnic and Cultural Sensitivity in Government Programs

Issue

The Euro-American older population has not been clearly recognized by the Government as an identifiable and distinct group, possessing resources and strengths that can be effectively employed to overcome barriers to service delivery. Nor were their desires to maintain their ethnic heritage and to transmit their cultural values and traditions to the younger generations recognized and supported. Myths and stereotypes afflicting the elderly in general in American society are especially harmful to ethnic aged who are in jeopardy due to prejudice and ridicule. There is a need to recognize that many Euro-American elderly do not receive their fair share of services and benefits to which they are entitled. Rigid rules and regulations often bar rather than facilitate access to services, particularly in housing and health care, where the need for assistance or subsidy is most acute because the burden to keep handicapped and functionally severely impaired elderly at home falls on the family and on ethnic associations.

The perceptions of Euro-American communities in terms of aging issues are frequently different from other communities; the needs of the elderly in those communities are frequently different from other communities. The policies this country has adopted to serve those communities have not reflected these distinctions, differences and needs. When we talk about culturally relevant services, we are talking mostly about an attitude to allow people to express themselves in their own culturally defined ways and to adjust services to their needs. Unless an environment is created to make policy-makers listen to these specific concerns, needs will not be met. Programs must be brought to the neighborhood -- instead of letting the neighborhood adjust to program rules and regulations. This can be very cost-effective. Ethnic identity and cultural patterns provide a source of support for elderly people. Public policy must take them into account. We must organize to insure that federal policies include ethnic values. We must insist that federal laws be responsive to the needs of ethnic elderly.

Recommendations

-- The Euro-American older population should be clearly recognized by all levels of government, as an identifiable group in the older population, and one whose various social, spiritual and economic needs and strengths should be recognized in both the programming and policy-making process.

-- The Federal Government should regulate its own bureaucracy by requiring its agencies to submit an "ethnic impact statement" with each new change either of personnel, of programs, or of procedures.

-- The Federal Government should require that every governmental advisory council reflect in its membership the ethnic and age composition of the people served by the program.

-- There should be more officials and administrators in the Federal Government who are sensitive to and supportive of the needs and interests of the Euro-American elderly and these persons should be persons of Euro-American descent themselves. In particular, there should be Euro-American ethnic affairs representation in such key areas of the Executive as the Office of the President, the Office of Management and Budget, the inter-agency coordinating offices, and the major cabinet posts of the Federal Government. There should be much greater representation of persons of Euro-American descent in the judicial system of the nation as a means of rectifying the omission of Euro-Americans in many instances, to appointive judicial positions.

-- Wherever there are concentrations of older Americans with limited English speaking ability, bi-lingual staff fluent in the ethnic languages of the elderly should be available to serve as brokers and facilitators between the formal and informal support systems that serve the elderly.

-- Any outreach program aimed at the older population, particularly with regard to various major public social programs, must have appropriate and effective ways of reaching and informing the older Euro-American population.

-- Funding should be set aside for the translation and printing of information in a variety of ethnic languages on existing public benefits (Medicare, Medicaid, etc.) to encourage the use of these support systems by elderly who are members of various ethnic groups.

-- Americans who identify themselves as members of distinct European groups should be fairly represented in federal, state and local government programs for the elderly as advisors, administrators and staff.

-- Government should encourage the maintenance of ethnic integrity in various living arrangements and in subsidized housing, including nursing homes and homes for the aged. A diversified range of housing options and altered Medicaid reimbursement practices are essential to enable ethnic communities to continue the support they provide to ethnic extended families: group homes, joint homes shared by small clusters of ethnic aged, congregate housing and nursing homes built around ethnic interests, etc.

-- All persons aged 75 and over and those persons who have achieved a state of functional dependency -- regardless of their age -- should be entitled to a full floor of social and human services as a matter of right. The only eligibility requirement should be that they are properly assessed to determine their precise needs.

Strengthening the Family Life of the Elderly

Issue

There is a generally accepted maxim regarding the families of elderly Euro-Americans. It is the recognition that even in our fast-paced world, the family remains a bastion of strength and stability in the ethnic community.

Despite mobility, social upheavals, and despite changing mores and lifestyles in this country, Euro-American families continue the age-old tradition of care and respect for their elderly members. Research conducted on many different ethnic cultures reinforces the commonly shared perception of the central importance of the family for the total welfare of its individual members -- including the elderly. The informal supports offered by the family to their aged members far surpass any government or public support both in scope, breadth and impact on individual well-being. But research on support system utilization by Euro-American elderly also shows that often families need government and community support to enable them to continue their care-giving activities. This is especially true for families who shelter and care for impaired elderly and struggle with the special burdens (economic and psychological) which accompany such activities in daily living. There is also a recognition that for the family-less elderly the ethnic neighborhood itself and the ethnic community at large serve as surrogate parents and family. Yet many families and many ethnic groups lack the necessary means to keep their functionally impaired elderly members at home in the familiar and safe environment which is so necessary for their survival.

In order to enable elderly Euro-Americans to live out their lives in accordance with their traditional values within their families, the following recommendations are stressed:

Recommendations

-- Incentives should be made available to families to assist ongoing care to the elderly by: tax deductions or credits; income supplements or constant attendance allowances, respite or relief services, adult day care; funds to make alterations or additions to existing homes; encouragement of intergenerational and shared housing; and improved Medicare and Medicaid benefits for in-home care. In addition, special federal aid should be provided in those cities in the economically declining Northeast and Midwest regions where such a large percentage of urban ethnic elderly reside.

-- Arts and humanities programs should draw from the diverse cultural heritage of Americans, especially our elders, as a means of strengthening family bonds. As an illustration, creative arts programs help maintain the mental health of the elderly while the media used can be a powerful tool of communication between generations.

Enhancing Mediating Structures and Neighborhoods

Issue

A large proportion of the neighborhoods in the northern part of the country in particular and in many industrial cities were established by Euro-Americans who strove to create living environments conducive to their style of life. Most of these neighborhoods have been self-sufficient communities offering to their residents the security, social, cultural, religious and educational services and activities that give meaning to their lives.

Human behavior is affected primarily through the surroundings where most of the experiences occur. Community means belonging. Elderly Euro-Americans in particular are bound to their communities by a host of relationships, including their affiliations in ethnic and cultural associations and voluntary organizations. Community for ethnic Americans means the neighborhood where they act out in a dynamic way life's never-ending joys and sorrows, triumphs and tragedies. The main concern is how to strengthen the capacities of the neighborhoods; how to prevent decay and destruction; how to restore and to preserve those unique and significant elements which are necessary for a sense of dignity, stability and security. Economic and social revitalization of urban neighborhoods is necessary for the very survival of the cities. For elderly Euro-Americans, the ethnic neighborhood offers a continuation of long-accustomed lifestyle, and an opportunity to play active and meaningful roles within the immediate society where they can make significant contributions in many areas of life: in the arts, in music, in literature, in the sciences, in folkways, in religious activities which enhance their spiritual, cultural and social spheres of existence.

In the 1980's, we should begin writing traditions -- writing a new history of the immigrant and ethnic experience in America and from that, articulate a new tradition of human service, of proper use of professionals, a new trend of helping each other, a new tradition of finding that the neighborhood residential place is where cultural endowment, future, and past, is. We are again seeing the value of such mediating structures as family, neighborhood, organized religion and ethnic reference groups in providing the sharing and intimacy which make for the richness of living.

In the name of equity and access, we now recognize that the family is the first mediating structure, especially for dependent members. The challenge in national social policy formulation is to develop and rechannel government aids to those means which will most efficiently help family, friends and other mediating structures in caring for their frail brethren.

These mediating structures need to reach out and embrace the most needy among the Euro-American elderly -- those who are isolated from the rest of the community, those who are forgotten, those who have no one to turn to when help is needed. Although church and family ties are strong in our ethnic groups, there are those who have alienated themselves from the community or those who have stayed behind in old neighborhoods, outliving family members and friends and have no informal support systems. These persons are also lost to the formal social service structure. Obviously there is a great need for a mechanism to find and reach the isolated elderly.

There is also the issue of the elderly Euro-Americans who find themselves gradually lost to the old ethnic neighborhoods by moving to the suburbs. There are larger and larger numbers of Euro-American elderly moving to the suburbs to be close to their children -- because it is safer. We have to look at what these new living patterns mean in terms of transmission of the culture to children and helping older family members if they don't live close by in the city. How are we going to use formal services? It will be important for elderly to have access to formal services if assistance from their children is not readily available.

Recommendations

In order to empower people in dealing with large institutions of public life which control a broad spectrum of services related to human needs; and in order to strengthen the capacity of ethnic neighborhoods and their mediating structures such as the church/synagogue, voluntary associations, neighborhood associations and ethnic organizations and services to serve the needs of elderly Euro-Americans, we recommend that:

-- Ethnic communities, groups and religious organizations should be given financial and other incentives from government and/or voluntary funding sources to create their own specialized living arrangements, social services, nutrition programs and other group self-help activities.

-- Residents of ethnic communities, especially the elderly and their organizations, should be formally involved in all private and public policy decisions involving service and resource allocations affecting their neighborhoods. The elderly themselves should be encouraged to assume a leadership role in the life and affairs of the neighborhoods they created and sustained through a lifetime of effort and involvement.

-- Community ethnic organizations need to become more sensitive to the specific needs of their elderly. The increasing costs of medical care are a burden to all ages; but the elderly, with their greater incidence of health problems, can benefit from the economies of such concepts and programs as the "health maintenance organizations" (HMO's). Ethnic societies should explore the feasibility of sponsoring HMO's, group insurance, consumer cooperatives, */ and other helping efforts based on group membership.

-- A more meaningful partnership between the formal and informal networks should be established in urban communities so that the government and professional agencies will be more effective in achieving their objectives.

-- Ethnic social service centers and medical clinics for the elderly should be established so that older residents will be able to fully utilize government programs for physical and social improvements.

-- National ethnic organizations, acting separately or together, should provide a "clearinghouse" for resources and information that are ethnically oriented in the areas of social services, health, nutrition and cultural programs as part of a total "self-help" program for the elderly.

-- Organized religion plays an important role in the lives of many ethnic elderly because it is an intrinsic part of their cultural identity. National leaders of the various religions should assume an aggressive role in activities which will strengthen this aspect of the lives of the elderly by such initiatives as the following:

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*/ The National Consumer Cooperative Bank should reach out to ethnic organizations with technical and fiscal support.

-- Train church/synagogue related personnel in broad aspects of the aging process and about common social issues affecting the elderly.

-- Create opportunities and programs for helping the elderly to act as transmitters of culture and to retain a vital and enriching role in society.

-- Utilize the church/synagogue leadership and facilities for educational and cultural programs including self-help concepts and age-integrated programs.

-- Use the communication and social action channels of churches and synagogues to inform the elderly about available services and benefits and to mobilize around common social issues such as transportation, neighborhood development, etc.

-- We strongly recommend that the city, state and the national government work to re-empower both neighborhood groups and ethnic subgroups within communities to provide services to older people.

-- Far too many elderly in ethnic communities are excluded from programs simply because they do not know about them. Effective outreach conducted by persons in the community is one way to alleviate this problem. We propose that where organizations of proven effectiveness are operating, they should be eligible for city, state and federal funds to provide important social or human services.

Improving the Health of Elderly Euro-Americans

Issue

The characteristics of the nation's elderly, those 65 years old and older, with respect to health in the broadest sense, is no different for elderly Euro-Americans as a whole. They, along with their fellow elderly peers from other ethnic groups, live longer and are surviving in larger numbers to attain venerable ages beyond the Biblical three score and ten. Consequently, their physical and mental health and related care are centrally important to them as individuals and to society. Chronic conditions afflicting 86 percent of the elderly and multiple chronic conditions encompass the large majority of elderly Euro-Americans. Similarly, short-stay hospitalizations are frequently used by the elderly and for longer periods than any other age group. As a group, however, elderly Euro-Americans perceive their capacities to perform health care related and supportive activities in a generally positive sense.

Only relatively small percentages of this population admit the existence of various impairments. In this respect they conform to the large majority of elderly Americans who, despite many health problems that beset them, consider themselves in good or excellent health.

Nevertheless, elderly Euro-Americans are very much concerned about their health. Their greatest concern is fear of becoming sick. This fear is particularly paramount for those elderly who have no one to turn to in case of an illness. These elderly in one study (Guttmann, et. al., 1979) comprised approximately half of the sample. Concern with physical health was perceived by the respondents in the study and by many participants in the two Miniconferences as one of the most important problems facing elderly Euro-Americans. It was also noted that medical costs for the seriously ill aged are now oppressively brutal, especially since Medicare is oriented toward short-term acute illnesses and accidents rather than to chronic care -- which is the greatest medical need of the elderly.

Vigorous group discussions stressed the willingness of Euro-Americans to play a more active role in caring for their long-term disabled elderly than has been generally recognized by public officials. At the same time, four key issues were identified as impacting on the quality of health care for elderly Euro-Americans:

1) A number of federal/state policies restrict unnecessarily the capacity of ethnic groups to cooperate in shaping the health condition of their members in a manner consistent with the unique heritage of each group.

2) There is discrimination against Euro-American ethnic groups as they try to form social supports for their elderly. They are not recognized as responsible organizations to sponsor programs and have not demonstrated their capacity to organize such programs.

3) There is obstruction to efforts to reallocate public funds from the less to the more preferred services, and

4) There is a need to support home-based health and other supportive care by federal funding.

Participants in the Miniconferences stressed that it is in the best interests of the elderly to remain in their own homes and their own communities -- but all reimbursement formulas work to encourage institutionalization. Specific legislative proposals need to be offered to Congress to provide tax credits for families who care for their elderly relatives -- for those expenses which are not covered by Medicare or another reimbursement program. Finally, we must deal with the discrimination which is rampant in the Medicare and Medicaid programs against home and respite care services. These are some approaches to reinforcing the family as a primary care giver.

Recommendations

-- Encourage federal reimbursement for improved home health supportive care and nutrition services.

-- Health maintenance organizations should be not only increased but steps need to be taken to assure that they can enroll aged. Specifically, wider population coverage can also broaden HMO services to include social or physical supports for the elderly as well as for physician care.

-- The enrollment should be encouraged of ethnic groups, as groups, to secure the economies of group enrollment now limited to full-time workers. Ethnic societies can be useful for this, and also to stimulate organization of HMO's for the elderly.

-- Encourage recognition of the increased training needs for health professionals and others to deal with increasing elderly population and specifically to encourage sensitivity to the needs of the ethnic elderly.

Addressing the Language Barrier

Issue

Euro-American elderly people are among the majority of "limited English speaking" members of society. Among the old immigrants in particular (those who came to the United States prior to World War I), there is a large proportion who even today, fifty or sixty years in this country, still do not speak fluently. There are many elderly who dream of returning to their native countries and who do not acquire English for fear of assimilation and subjection of their values to the majority culture. There are others who came as illiterates and never had the opportunity to obtain formal education. And there are those whose accent is so distinctive as to render them unwilling to use English in their communications with public officials.

According to the 1975 Census of the United States Population, only 10.7% of those 65 years old and over used English as their usual language; that is, the great majority of the nation's elderly use languages which are not the one considered to be native to this country. Use of other than English varies from one Euro-American group to another. For example, close to half of the Italian elderly do not use English in their usual communications -- compared to one-fourth of the German, one-fifth of the Greek, and one-third of the French elderly. When all Euro-Americans, both first and second generation, are combined whose mother tongue is non-English, close to 30 million people emerge as "foreigners". If we take the same 11% of the total population of 65 and over who are Euro-Americans, then close to one-half of the elderly who belong to any of these ethnic groups do not speak English.

Whether by choice or necessity, the consequences of not being able to use English fluently when needed can be rather devastating. As a Hungarian representative notes: "Survival is the key word in reference to speaking English. If not, you are deprived of every available service -- income, health, housing, etc. Offices and hospitals do not provide translators."

We could go on describing the pains and agonies an old and lonely person has to suffer, the degrading remarks and often insults they have to take because they are older, alone and not able to speak and defend themselves because of a language barrier. The refusal to recognize and deal with this critical problem literally denies these same individuals the right not only to quality existence, but also threatens basic survival.

Participants were very concerned about providing assistance in regard to foreign language for elderly people. The only assistance the Social Security Administration provides is for Spanish-speaking people. If someone speaks another language, there is no help at all. We should do something to make the Federal Government more aware that more assistance should be provided to non-English speaking people.

Economic Security for Elderly Euro-Americans

Issue

A large, if not the largest problem for the elderly is maintaining income in the face of retirement or diminished earning capacity, says Dr. Alvin Schorr.*/ On one level are those with good earnings records, some savings, the capacity to continue earnings into advanced years, decent social security, and private pensions. Things will not go badly for them. On the lower level are people who have few if any of these advantages into old age. Social security will do relatively less well for them than now. Many will be women who never married, or divorced, or whose husbands died. In terms of retirement, such women are in terrible trouble now; the future appears to hold worse for them.

Euro-Americans, that is, those Americans who retain a sense of European descent and connection, have some stake in what happens to those with moderate incomes.

In modern times, a critical problem of aging lies in feelings about losing command over one's self and surroundings. The issue has to do with changes in bodily functioning, with power once exercised through position or work and with power exercised in relation to family and friends. Some of these changes are inevitable but modern American practices enforce an abrupt transition, once uncommon, from power to powerlessness. Yesterday, one worked; today one draws a pension. Today he disposes of no product, no promotions and has turned over his home and savings to children in order to qualify for government benefits. In a curious way, even current emphasis on informal networks and family supports may come to undermine the old person's sense of self-command.

The day-to-day arrangements between old people and their families are a complex blend of economic exchange and services in which it is often not clear who is the net beneficiary. In early Colonial practice, brought here from Europe, men carefully, and in documents with legal force, arranged to exchange inheritance for care for themselves and their wives. The practice lives on in widespread, current understanding that a care-giver inherits a preferred portion of an estate. In family relationships, sentiment and responsibility play large roles but they interact with true power to dispose of money and property. Everyone understands the bargaining power inherent in money and property.

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*/ We are indebted to Dr. Alvin L. Schorr, Leonard W. Mayo Professor of Family and Child Welfare at the School of Applied Social Sciences, Case Western Reserve University for materials used in this section of the report which were taken from "Social Policies for the 80's", a paper presented at the White House Miniconference for Euro-American Elderly, December 6, 1980, Cleveland, Ohio.

SSI is more attractive than Old Age Assistance was, but it is a welfare-type program still. And in order to qualify, legally and reluctantly the elderly strip themselves of assets that are, on the whole, small in amount though significant to them and their families.

We explicitly claim to honor the bonds of family and idealize the image of the family as care-giver; yet federal regulations do not provide any reimbursement or financial assistance to family members trying to live up to their responsibility. Recently, the Internal Revenue Service started circulating regulations to implement the so-called Family Rental Tax, whereby a taxpayer renting to a family member cannot take the same deductions as an individual who rents to a stranger. We, who know the value of family support and assistance, must protest these policies. Congresswoman Barbara Mikulski has, in fact, co-sponsored a bill that would remove this inequitable tax from the tax code.

A system of social security that was truly engaged in strengthening the family relationships of the elderly would not so undermine their position. What might we do? We would end the one-third reduction of SSI when the old person shares a dwelling, and we would end reductions when family members make contributions. It cannot really be said that the current provision forces old people to live separately from their children. Living together or separately is not an ad hoc decision like buying the cheapest car. Rather, living together is characteristically the pattern of the poorest families. What the one-third reduction does is single out the old people and families in the most adverse circumstances and deprive them a little more. As for deductions from SSI when there are contributions, no more than 3 percent of all old people receive cash contributions from children. In this matter, the government is nitpicking. The effect of the rule is probably that contributions are given in kind rather than in cash, and there is petty evasion. As for those who have transferred assets to qualify for SSI, they have yielded up one element of a continuing sense of power and the capacity to negotiate with family members.

The elaboration of rules to administer those programs inevitably involves th government in internal family affairs, often unjustly and in ways damaging to the old person and his family.

There is a need to retain and strengthen the single universal retirement program that we have created. With specific reference to the maintenance of one's power and authority in growing old, one affirmative idea is the so-called constant attendance allowance. It would provide a modest sum of money for the retired aged who require home care. The frail or very old certainly need additional help.

Retirement benefits need to be changed -- over a long period of time, if necessary, at no net cost -- to pay higher levels of benefit at say, 72 and then 80 years of age. In this way, we would do most of the job without any administrative cost at all, placing power to manage together with money in the hands of old people.

Recommendations

-- There should be group homes, joint home sharing by small clusters (2-10) of ethnically similar aged; congregate housing built around ethnic interests; independent housing with social support services built in; comprehensive living environments (which assure living independently in one's own apartment, or doing so with limited attendant and physical assistance, or care in a nursing environment -- all in the same complex); boarding homes; and help with physical repair or maintenance of one's own residence.

To assure this, rigid income limits should be altered as to who is entitled to enter assisted housing units or to use Housing Section 8 programs. The low-middle income population desperately needs such housing options as do the very poorest. Removal of, or relaxation of, income limitations will help many to use their own incomes to secure least restrictive living arrangements.

-- A "negative income tax" should be instituted to provide an adequate level of income to all older people.

Empowerment and Volunteerism

Issue

Elderly Euro-Americans share with other American elderly people a strong rejection and unwillingness to be relegated to the sidelines of society. They do not want to be excluded from the many happenings around them, nor do they want to spend their remaining years lulling about on porches and in armchairs. Rather, they wish to be active, contributing members to their communities. Their help to the younger generation is well documented. According to the Harris Poll (1977) 90 percent of those with children or grandchildren said that they give gifts to them; 68 percent help out when someone is ill, 65 percent take care of grandchildren, and smaller, but significant, percentages of the elderly help their family members in other ways. These volunteer activities by the elderly enable many families to save substantial sums that would otherwise be spent on hiring outside help -- not to mention the psychological value of care provided by the elderly to the young.

In another study of eight Euro-American groups of elderly (Guttmann, et. al., 1979), volunteer support for others varied from group to group; however as a sample, half of the respondents helped someone financially, with fixing things, with shopping and caring for the ill -- aside from the assistance given to their own family. The types of volunteer work most commonly engaged in by the elderly include working in hospitals and clinics, driving the ill, the aged and the handicapped, involvement in voter registration and advocacy, and friendly visiting to the homebound.

Volunteer activities among elderly Euro-Americans are expressions of the self-help ethic, and spirit of togetherness, traits that are eminent in the ethnic community. Ethnic communities need to develop a network of interested volunteers to provide support services to Euro-American elderly in need. There is also a need to develop a knowledge base of public policies and services which can be utilized to better the lives of the elderly.

Many elderly need help with translation of government rules and regulations into their native languages. Others need help with information and referral services. Still others need support and help of bereaved elderly. There are also social and cultural activities which offer opportunities (along with those already cited) for volunteer services.

Local helpers, clergy and others, are among those most eagerly sought by the elderly when they need help. In some cases these volunteers should refer people to a professional agency.

Participants in the workshop stressed that volunteering gives people a chance to acquire and use special skills. Illustrations of successful volunteer activities in the ethnic community included those in which the ideas, such as kitchen hot-line came directly from the people who served as volunteers in their neighborhoods. A four-year research and demonstration project which utilized volunteer ethnic neighborhood helpers in the provision of mental health support services (Neighborhood and Family Services Project in Baltimore, Maryland) demonstrated the value of volunteer services in enhancing and strengthening the informal helping network and in bringing it in close contact with the professional helping network.

The overriding issue in volunteer activities performed by elderly Euro-Americans is the economic security people must have to better reach out to those in need. Specifically, policies should be aimed at enabling those who are able to function, to continue even if part-time, working. There is a need to eliminate mandatory retirement altogether and to base the economy on full-employment. There is also a need to empower ethnic elderly women to become equal partners in building a strong society. Therefore, many participants expressed support for the passage of the Equal Rights Amendment.

Recommendations

-- Organizations in both the public and private sectors, should take action to encourage the mature worker to voluntarily continue productive involvement in the economic life of the nation.

-- Government agencies, businesses, educational, cultural and recreational organizations and the media should help focus attention on the skills and experiences of older persons that can be used in productive ways.

-- Education for pre-retirement planning should be included in the curricula of high schools and colleges.

-- Retirees should be given the opportunity to share their experiences with the younger generations.

-- Services of elderly Euro-Americans should be recognized in the general society.

1981 WHITE HOUSE CONFERENCE ON AGING

MINICONFERENCE ON EURO-AMERICAN ELDERLY

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the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on
Intergenerational Cooperation and Exchange

MCR-11

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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EXECUTIVE SUMMARY

STRATEGIES FOR LINKING THE GENERATIONS results from a series of 24 community workshops, three regional meetings and a national conference that involved more than a thousand persons across the country. The purpose of these meetings was to provide the 1981 White House Conference on Aging (WHCOA) with feasible recommendations for increasing cooperation and exchange between younger and older individuals, as well as between the organizations and institutions that serve people of different ages.

This report sets forth a feasible and desirable agenda for the 1980s by identifying many specific actions which can and should be taken by various public and private institutions. Increased intergenerational cooperation and exchange is an objective that can be achieved during the coming decade in a manner that will enhance rather than detract from other national priorities. Costly Federal programs are not needed: Most initiatives can and should be undertaken at the local level. The recommended role for government is to reduce existing legislative or regulatory hindrances and to support local efforts through information-sharing and targeted research and development within currently funded programs.

The organization of this report is as follows:

Section I: Introduction
Section II: Benefits of Intergenerational Cooperation & Exchange
Section III: Policy Recommendations

a. Elementary and Secondary Education
b. Higher Education
c. Social Services
d. Transportation
e. Housing and Neighborhoods
f. Crime Prevention
g. Religion
h. Health
i. Employment

Section IV: Feasible Programs
Appendix A: Description of the WHCoA Mini-conference Process
Appendix B: Acknowledgements

INTRODUCTION

During the 1970's, the Federal Government embarked on important initiatives to expand the range of services to the elderly. During the same period, important demographic changes occurred which have affected the role of the elderly in the family, the community and the economy. The White House Conference on Aging affords an important opportunity to examine all of these changes. The conference is also an opportunity to develop recommendations that can provide guidance in the development of policies responsive to the needs of older Americans during the 1980s.

In contrast to earlier White House Conferences on Aging, the 1981 Conference will devote considerable attention to "intergenerational" or "age-integration" issues. Intergenerational concerns are basic to the field of aging, since virtually all aspects of society are affected by the manner in which individuals of different ages relate to each other. Unfortunately, there seems to be a growing consensus that existing relationships between youth and older people are not optimal. The two groups are finding themselves in direct competition for scarce resources. In addition, some gerontologists are beginning to argue that new programs established for the elderly are causing further age-segregation, which cannot help but increase negative sentiment between older and younger groups. Such sentiment is also fostered by media reinforcement of the image of youthful hostility toward older people and the fear of criminal victimization by the young.

In the 1980s, government resources probably will not be available to fully meet increasing human needs. Tax-cutting measures at the federal, state and local levels are likely to exacerbate tension and competition between older and younger individuals and the organizations that represent them. These tensions will have a negative impact on the ability of the United States to effectively utilize the resources available for younger and older persons. As a society, it is imperative that we seek to counteract trends toward inappropriate age-isolation and intergenerational conflict by developing ways to bring together youth and older persons for their mutual benefit.

Consistent with its historical role as a leader in the field of aging and in the area of intergenerational activities, NCOA convened "Strategies for Linking the Generations" to provide direction and focus for future efforts in this area. More than one thousand persons have participated in the series of community, state and national meetings that have been held throughout the country (cf. Appendix A). The major purpose of the mini-conference was to develop a feasible policy and programmatic agenda for the 1980s; it concentrates on specific recommendations for action at the community, state and national levels. The task of issue definition and development has been left to our colleagues on the various WHCoA Technical Committees. The primary focus was on the creation of strategies for linking inindviduals over the age of 60 with youth under the age of 25.

The role of the middle generations as well as intra-family issues were not examined at greater length because of the need to keep the scope of the conference manageable.

II. BENEFITS OF INTERGENERATIONAL COOPERATION AND EXCHANGE

A shortage of opportunities exists for both youth and older persons to be active, contributing members of society. At the same time, there exists a shortage of financial and human resources available to meet the needs of both young and old. Increased intergenerational cooperation and exchange can enable the simultaneous development of meaningful roles and needed services for individuals of all age groups.

By working together young and old can concentrate on concerns common to both groups. This in turn may diminish the potential for conflict between these two groups and reduce any insecurities either group may have, including, for example, the fears expressed by many elderly of crime at the hands of youth. In this way, increased harmony between generations benefits not only specific groups of youths and elderly, but entire communities as well because it engenders more informed and resourceful citizens.

Intergenerational relationships can help expose young people to a holistic view of life. Through interaction with older adults, youth can gain knowledge of the past, an enlarged perspective on the present, insight into the future and a sense of life as an ongoing process in which aging is one fundamental component.

Intergenerational cooperation and exchange may enable older people to cultivate meaningful new relationships which can provide a great deal of support for them particularly at times when they are suffering the loss of relatives and friends and experiencing the onset of chronic illnesses which may reduce their physical functioning. In addition, new intergenerational friendships may provide the older person with a better understanding and appreciation of the values and problems of youth. They can also add meaning and satisfaction to the lives of older people by allowing them opportunities to influence the future by transmitting their skills and knowledge to youth.

In an era of declining resources, public and voluntary agencies which serve youth or older people may benefit from greater cooperation. By pooling some of their resources, it may be possible to develop joint projects or cooperative ventures which will more effectively meet needs of both age groups.

Intergenerational cooperation and exchange can also foster increased awareness and a better understanding of the aging process and the elderly. Young and old will be able to dispel some of the myths that separate them. Young people will become aware of the diversity which exists among the aged and recognize that every individual has a worthwhile contribution to make to American society.

III. POLICY RECOMMENDATIONS

A primary objective of "Strategies for Linking the Generations" has been to identify specific actions which can and should be taken during the 1980's to increase intergenerational cooperation and exchange. The task outlined to participants in the local, regional and national meetings was to identify and recommend feasible approaches that can be implemented at the community level which do not require new government interventions or massive infusions of federal funds. Recommendations for action by state and national officials are made in the context of what participants believe should be taking place at the community level. An extensive process was completed to assure that all of the recommendations in this report truly reflect a consensus of participants in the local, regional and national meetings.

Policy recommendations are organized into nine topic areas: Elementary and Secondary Education; Higher Education; Social Services; Transportation; Housing and Neighborhoods; Crime Prevention; Religious and Spiritual Well-Being; Physical and Mental Health, and Employment. For each topic, recommendations have been made for local, state and national action. For each recommendation, a consensus was reach that the proposed action was both feasible and desirable and that it could be implemented during this decade within the context of current social, economic, and political conditions.

ELEMENTARY & SECONDARY EDUCATION: Recommendations for LOCAL Action

1. An understanding of the aging process should be included in the educational process at all levels. Older persons should be tapped as resources in whatever ways they can be involved.

2. Educational systems and other cultural institutions should actively encourage the involvement of older persons as employees or as volunteers to complement regular staff in a wide variety of educational activities and programs, including:

   a. tutors, vocational education teachers, teacher-learners, health aides and assistant coaches;

   b. resource persons in educational programs such as Heritage Arts & Crafts, Living History, Facts & Myths About Aging, Career Exploration Seminars, discussions on topics, such as social and political issues and values clarification;

   c. mentors and role models.

ELEMENTARY & SECONDARY EDUCATION: Recommendations for LOCAL Action

3. Educational systems should explore developing programs through which youth would provide needed services for credit, pay or on a volunteer basis to older persons, such as chore, escort, handyman, repair, shopping and weatherization services.

4. Educational systems should develop opportunities for youth and older persons to interact on a peer basis. For example:

   a. some secondary school classes could be opened up to persons of all ages on a space-available basis;

   b. "Service Swaps" between generations could be organized;

   c. intergenerational service teams could help others in need, or do joint projects.

5. Educational systems should explore the feasibility and desirability of making school activities and services available to older persons, e.g., cafeterias, health, gymnasium, auditorium facilities and transportation service. These facilities and services could be shared by both student and older populations. Schools that are already closed might be turned into multigenerational community centers.

6. Local Boards of Education, P.T.A.'s and Teacher's Groups should be encouraged to take the initiative in stimulating exploration and discussion of intergenerational issues.

ELEMENTARY & SECONDARY EDUCATION: Recommendations for STATE Action

1. Each State Department of Education should take responsibility for stimulating intergenerational activities in educational systems. Conferences, tasks forces and clearinghouses should be developed for organizing collaborative efforts between the State Office on Aging, the Department of Education, the State Teachers Association and community groups.

2. The State Department of Education should be encouraged to include a focus on aging and the utilization of older persons as resources in the schools as a requirement for recertification of teachers.

3. The State Department of Education should encourage and enable educational systems to develop and incorporate curriculum relating to aging. Printed and audio-visual materials used in the schools should be reviewed and revised as appropriate to eliminate ageist bias. States should disseminate curriculum models and resources to facilitate local curriculum reform.

ELEMENTARY & SECONDARY EDUCATION: Recommendations for STATE Action

4. State Legislatures should examine whether or not legislation and/or financial incentives are necessary and desirable to facilitate the use of school facilities and resources by all age groups and to promote greater involvement of older persons in helping roles.

ELEMENTARY & SECONDARY EDUCATION: Recommendations for NATIONAL Action

1. There needs to be a national consensus that an understanding of the aging process is important to people of all ages and not just to people who are pursuing careers in gerontology. Public and private national organizations should seek ways to support this consensus and to foster and facilitate the development of intergenerational programs.

2. Public and private agencies and organizations involved in aging or education should support research that examines the effects of intergenerational activities and for the development of effective approaches to intergenerational programs.

3. The Department of Education should be charged with the specific responsibility of examining ways to facilitate linking the generations through the educational system.

HIGHER EDUCATION: Recommendations for LOCAL Action

1. Colleges and universities should seek to actively involve older retired persons (educators and other professionals) in higher education settings via:

   a. guest lectures in various courses (in special area of expertise or regarding aging in general);

   b. teaching a course in area of expertise;

   c. "filling-in" for those on sabbatical;

   d. counseling (e.g. career, personal, family, ethnic issues).

   e. emerti alumni programs

   A "Skills Bank" could be adopted as a means to implement this type of program.

2. Service-learning experiences and field practicum should be encouraged in appropriate disciplines at the community college, college, and university level to increase intergenerational sensitivity, improve student learning, and expand and enrich services for older persons (e.g., architecture students working with a task force of older persons to eliminate architectural barriers; history majors using young and old in an oral history program; or allied health majors providing health screening services to older people in the community). Mutual exchange should be an integral part of all activities. Specifically:

   a. Colleges should hold seminars for faculty and field supervisors on the importance of including such intergenerational practicums and ways to facilitate such practicums;

   b. Institutions of higher education and Area Agencies on Aging should create a task force to encourage better cooperation between the academic departments on campus and community agencies and organizations concerned with older persons.

   c. Community agencies, gerontologists, and experiential educators should work closely with the college work-study office and take advantage of new amendments to the Higher Education Act which provide financial incentives for developing jobs in community service-learning.

   d. Faculty members should be encouraged to give credit or course substitution options for community service activities, as appropriate.

3. Colleges, junior colleges and universities should explore the desirability and feasibility of making facilities more accessible to older persons by strategies such as:

   a. correcting architectural barriers;

   b. providing easy and accessible parking;

   c. sharing facilities such as cafeterias, gymnasia, and theaters with senior citizens programs and organizations.

   d. examining the feasibility of intergenerational dormitories as a means of utilizing excess housing capacity;

   e. scheduling courses to respond to academic needs/wants of elder persons;

   f. developing a student escort service to assist in transporting older persons to and from the campus.

HIGHER EDUCATION: Recommendations for LOCAL Action

g. encouraging the development of senior citizen housing projects adjacent to the campus.

4. A life cycle course with a substantial gerontology/geriatrics component should be a general college requirement on all levels of higher education.

HIGHER EDUCATION: Recommendations for STATE Action

1. States should provide educational institutions with financial incentives to serve older adults by allowing older students (both matriculated and non-matriculated) to be included in reimbursement formulas based on FTE's (Full Time Equivalents).

2. Cooperative Extension services at land-grant colleges should seek to facilitate intergenerational projects in 4-H programs, Future Homemaker groups, Agricultural programs and Nutrition Education, by linking university resources with county extension networks.

3. States should encourage colleges and universities to include life-cycle courses with a substantial gerontology/geriatrics component as part of their basic educational requirements.

HIGHER EDUCATION: Recommendations for NATIONAL Action

1. The federal government and private sector should fund development, dissemination and adaptation of innovative program models which bring college students and older persons together for their mutual benefit in areas such as:

   a. older persons as resources on campus;

   b. innovative educational programs for older adults;

   c. service-learning (through courses or college work-study);

   d. facilities sharing.

2. Congress should study whether or not legislation and/or financial incentives are needed and desirable to enable more of these intergenerational activities.

3. Congress should revise and expand the current federal service-learning program, University Year for Action, to make it more flexible and viable. Special emphasis should be given to developing intergenerational service-learning.

4. Intergenerational focus should be integrated as a priority in existing legislation (e.g. FIPSE, Title I of Higher Education Act, Elementary and Secondary Education Act, ACTION, DOL, HUD, AOA, HHS, Agriculture, etc.).

SOCIAL SERVICES: Recommendations for LOCAL Action

1. A series of community-wide interagency programs or forums should be organized to increase consciousness and awareness of intergenerational issues and benefits and to encourage service delivery agencies to develop intergenerational program linkages. These programs should include older and younger individuals as well as service providers.

2. Community service delivery agencies and organizations, especially those with youth membership, should be encouraged to examine the unique ways they can involve older people in joint activities with younger people.

3. Local funding agencies (e.g. foundations, United Ways, service clubs, banks and public funds) should be encouraged to support intergenerational projects between youth and older persons, senior and youth centers, housing developments, nursing homes, recreational systems and other community-based agencies.

4. A group of existing community service providers should be organized to facilitate intergenerational activities by paying particular attention to legislation, funding and regulations on an ongoing basis.

5. Area Agencies on Aging should be encouraged to put intergenerational issues and program planning on their agenda and to include at least one intergenerational project per year in their plan.

6. Skills banks need to be established as a local resource to provide people for specific intergenerational programs or services.

SOCIAL SERVICES: Recommendations for STATE Action

1. State legislatures should examine and change present policies which do not enhance and support the family's structure (e.g. loss of SSI and Medicaid benefits when elderly are taken into family's homes). Legislatures should also eliminate disincentives for family supports in housing policies.

2. State agencies should encourage the support of and remove the obstacles to intergenerational projects between youth and older persons in senior centers, senior housing developments, nursing homes, recreational systems and other community-based agencies.

3. The governor should establish an interagency task force consisting of representatives of youth and aging groups to facilitate expanded intergenerational activities by human service agencies. This task force would focus special attention to legislation, funding and regulations that inhibit intergenerational programming.

SOCIAL SERVICES: Recommendations for STATE Action

4. State agencies should examine licensing regulations to assess the extent to which previous experience can be utilized as a substitute for formal training in services, such as child day care provided by older persons.

5. The state tax credit system should be reviewed and revised to provide tax relief for older persons in exchange for services provided, particularly through intergenerational programs and activities.

6. The State Office on Aging should act as a catalyst and a clearinghouse for intergenerational activities by providing resource guides, technical assistance and funding.

SOCIAL SERVICES: Recommendations for NATIONAL Action

1. Present policies should be examined and changed, and financial incentives must be developed to enhance and support the family structure, (e.g., make sure SSI and Medicaid do not discourage older persons from living with relatives).

2. Federal agencies should provide funding for intergenerational projects sponsored by agencies involving youth and older persons.

3. Government and private sector training programs should include intergenerational concepts and be used for specific training in intergenerational programming.

4. The Federal government's commitment to further intergenerational programs, particularly ACTION's RSVP and Foster Grandparent programs should be strengthened. ACTION's policies which restrict intergenerational activities should be reviewed (e.g. transportation).

5. Existing findings on the benefits of intergenerational programs involving persons of all ages should be compiled and disseminated by organizations such as NCOA or the U. S. Administration on Aging.

6. A national media campaign should be launched to negate stereotyping of both old and young and to promote age-integrated programs.

7. Innovative approaches for intergenerational cooperation and exchange must be developed and supported to respond to the language and cultural uniqueness of non-English speaking elderly.

TRANSPORTATION: Recommendations for LOCAL Action

1. Communities should encourage the development of transportation systems and programs which serve both the old and the young in the following ways:

    a. School districts should allow buses to be used to transport older and younger people together.

    b. Area Agencies on Aging and local Boards of Education should examine the feasibility of pooling available transportation resources.

    c. Communities need to identify volunteer drivers who would transport both young and older people.

    d. Community organizations need to be encouraged to provide reciprocal escort services for youth and elderly in the community.

    e. Communities should allow the unrestricted use of bus passes by older persons who participate in intergenerational paid and volunteer work experiences and who are in need of some financial assistance.

2. Reimbursement on the basis of need should be made available to drivers providing transportation to persons involved in paid or non-paid intergenerational activities.

3. Programs need to adopt models that provide liability coverage for volunteer drivers (e.g. the ACTION model).

TRANSPORTATION: Recommendations for STATE Action

1. State insurance commissions should address liability issues to enable full utilization of school and other buses which could be used to transport volunteers.

2. State governments should develop ways to adequately cover volunteer drivers.

TRANSPORTATION: Recommendations for NATIONAL Action

1. Transportation initiatives should be coordinated by agencies serving populations with similar needs to foster intergenerational programs and to make transportation systems more cost effective.

2. The private and public sectors need to continue to increase efforts to provide adequate transportation systems for youth and older people together.

3. The federal government should consider extending ACTION's model for liability insurance to cover other volunteer transportation efforts.

TRANSPORTATION: Recommendations for NATIONAL Action

4. Tax deductions provided for the travel of unsubsidized volunteers should be equal to that provided for business purposes.

HOUSING AND NEIGHBORHOOD: Recommendations for LOCAL Action

1. Communities should seek to provide older and younger people with more housing options e.g., (a) small group homes with younger people who live-in; (b) intergenerational public housing projects; (c) age-integrated home-sharing programs.

2. Local government and neighborhoods should examine and change zoning laws, deed restrictions and building codes which prohibit home-sharing and intergenerational living.

3. Elderly housing projects should consider developing on-site child care centers and in-house tutorial programs which might have economic and social benefits to the older persons involved.

4. Special efforts need to be made to provide older people in senior citizens housing projects with opportunities to interact with youth.

5. New development planning should focus on creating neighborhoods where increased intergenerational interaction can occur, e.g. senior citizen high rises built contiguous to colleges or secondary schools.

6. Neighborhood-based senior and youth organizations should be brought together to examine possible projects of mutual benefit which would contribute to neighborhood cohesion. Possible projects include community gardens, food and other cooperatives, special weekends and holiday activities (e.g., sharing July 4th, Thanksgiving and Christmas experiences) and projects for bartering or exchanging goods and services between old and young.

HOUSING & NEIGHBORHOOD: Recommendations for STATE Action

1. States should examine and change state policies which do not enhance and support family structure.

2. States should seek to complement Federal housing programs by supporting the development of alternate housing arrangements such as those described above.

HOUSING & NEIGHBORHOOD: Recommendations for NATIONAL Action

1. The policy for Federal housing funds should be to support a variety of housing options for all people, including age-integrated housing.

2. HUD should fund demonstration projects designed to test the feasibility and viability of a variety of intergenerational housing options including projects adjacent to college campuses.

CRIME PREVENTION: Recommendations for LOCAL Action

1. Police departments, volunteers and other neighborhood based organizations should sponsor crime prevention programs such as seminars, study groups and demonstration programs on an age-integrated basis.

2. Supervised escort systems utilizing existing youth groups should be developed to provide escort services to older persons on a regular basis.

3. Neighborhood-based crime prevention programs such as Neighborhood Watch, Helping Hand, Project I.D. and liaison groups should be developed on an intergenerational basis.

4. Local government and businesses should be encouraged to fund intergenerational crime prevention projects.

CRIME PREVENTION: Recommendations for NATIONAL Action

1. The Omnibus Crime Control Act of 1965 should encourage states to develop a plan of action to protect and assist elderly victims of crime and to encourage intergenerational approaches to crime prevention.

RELIGIOUS & SPIRITUAL WELL-BEING: Recommendations for LOCAL Action

1. Churches/synagogues and other organized religious groups should be encouraged to develop intergenerational programs and services which are neighborhood based and promote the total well-being of people. To achieve this goal, these neighborhood based programs and services should be provided with resources such as training, technical assistance and funding.

2. Discussion groups for the exchange of ideas and concerns between the old and the young should be organized. Churches could sponsor discussions that explore mutual interests, ethnic and religious heritage, and ethical and moral values.

3. Churches and religious institutions should recognize and make greater use of the spiritual contribution and leadership that the elderly can make in the full ministry of the church.

RELIGIOUS & SPIRITUAL WELL-BEING: Recommendations for LOCAL Action

4. Service projects should be developed where young and old work together to help others in need, particularly projects which could be of assistance to homebound members as well as to the community-at-large.

5. Local religious leaders should develop educational programs on aging and encourage all age groups to participate.

6. Local churches and synagogues should be encouraged to use their physical plant for intergenerational activities on week days when building is not being used for services.

7. Churches and Synagogues should sponsor regular intergenerational events that bring young and old members together for social and educational experience.

RELIGIOUS & SPIRITUAL WELL-BEING: Recommendations for NATIONAL Action

1. National religious organizations including the National Council on Churches, National Interfaith Coalition and B'nai B'rith and other organized religious groups should take a leadership role in encouraging local parishes and institutions to develop a variety of intergenerational activities. One strategy would be to provide local groups with information about programs and resources to help them develop local service/program options.

2. Courses in gerontology should be included in the curricula of all divinity schools and seminaries. These courses should include a field component through which students gain experience in working with elderly parishioners or congregation members.

PHYSICAL & MENTAL HEALTH: Recommendations for LOCAL Action

1. Organizations serving young and old should develop collaborative programs designed to break down myths and stereotypes, improve physical and mental health of the individuals involved and to foster a sense of individual self-worth.

2. Community organizations should be encouraged to develop intergenerational activities such as hotlines, community recreation and physical fitness programs, health fairs and friendly visitor programs to increase exchange and communication between the young and old.

3. Churches, synagogues, local religious organizations and neighborhood based social groups and organizations should be encouraged to develop intergenerational neighborhood services and programs designed to improve the mental and physical health of local residents.

PHYSICAL & MENTAL HEALTH: Recommendations for NATIONAL Action

1. National organizations such as NCOA and National Council of Churches should actively promote neighborhood based intergenerational service models that improve physical and mental health of the young and old. Technical asistance and information on local programs and resources should be provided to enable community organization to explore local options.

2. Federal regulations governing congregate meal programs for different age groups should be revised to encourage intergenerational programs.

3. The Administration on Aging, National Institute on Mental Health and other private, public and voluntary agencies should develop, support and continue geriatric mental health training programs, service-learning programs on university and college campuses, professional health training programs and other programs in which the young and old provide gap-filling health and social services to each other.

4. Scientific research should be encouraged through the National Institute on Aging toward better understanding of the processes and mechanisms that either bind the generations together or keep them apart.

EMPLOYMENT: Recommendations for LOCAL Action

1. There are opportunities in virtually every community to create part-time jobs for older persons and youth in intergenerational services:

   a. Youth organizations and employment agencies should encourage part-time jobs for youth that are intergenerational in nature such as respite care, escort services, companionship, shopping and house cleaning;

   b. Senior organizations and employment services should seek to develop part-time jobs for older persons that are intergenerational in nature such as child care, babysitting, general housecleaning, after school monitoring, etc.

   c. Local banks, chambers of commerce, service organizations and local businesses should be encouraged to help get these businesses started.

2. Business organizations should take initiatives to experiment with intergenerational training, re-training and job-sharing programs.

EMPLOYMENT: Recommendations for STATE Action

1. The Governor should appoint a task force which would include the State Office on Aging, Youth Employment Unit of the State Employment Service and local corporations for the purpose of developing jobs in which old and young provide services to each other.

2. Tax incentives should be given to businesses and individuals that provide career exploration and apprenticeship programs involving retirees and youth.

EMPLOYMENT: Recommendations for NATIONAL Action

1. The Federal Government in its own employment programs should be encouraged to foster more research and demonstration efforts in the area of intergenerational work experiences.

2. The Small Business Administration should seek to foster the development of local businesses related to intergenerational services.

3. Major corporations that hire large numbers of part-time workers (e.g. McDonalds) should be encouraged to hire more older persons.

IV. FEASIBLE PROGRAMS

One outcome of"Strategies for Linking the Generations" has been the identification of feasible intergenerational programs and approaches currently going on in communities throughout the United States. For most recommendations set forth in this report there is evidence of success in at least one community. Space restrictions necessitated omitting this information from the report to the WHCOA. A complete version of this report, published by the National Council on the Aging (NCOA), includes brief descriptions of feasible programs that have been identified. During the Summer or Fall of 1981, NCOA also plans to publish a planning and resource guide which will include in-depth profiles of feasible intergenerational programs.

APPENDIX A

A Description of the Process of the WHCoA Mini-conference on Intergenerational Cooperation and Exchange

In August 1980, the National Council on the Aging was officially designated by the White House Conference on Aging to convene a Mini-conference on intergenerational concerns. NCOA staff and a small cadre of volunteers developed and implemented a process designed to maximize community input, to examine local state and national perspectives and to develop a comprehensive series of policy recommendations that are both feasible and which have a broad-based consensus of support.

During the Fall of 1980, a series of one-day workshops were held in 24 selected communities across the country. Invited to participate were persons active in innovative intergenerational activities as well as key representatives of educational institutions, youth groups, community service agencies, senior organizations and religious organizations.

The major topics addressed by each group were:

- Benefits of intergenerational cooperation and exchange
- Approaches to increasing linkages between the young and old
- Policies that hinder intergenerational cooperation and exchange
- Recommendations for federal, state and local policies that would foster intergenerational cooperation and exchange.

Approximately 1,000 participants were involved in the 24 community workshops. A breakdown of Organizations Participating in the Mini-conference*

Service Organizations for Older Persons	24%
Public Schools (Elementary & Secondary)	9%
Area Agencies on Aging	8%
Colleges and Universities	17%
Religious Institutions	3%
Youth Groups	4%
Red Cross	2%
RSVP	3%
AARP	1%
Foster Grandparents	4%
Parks and Recreation Departments	1%
Congressional Staff Persons	1%
Libraries	1%
Media Representatives	1%
Older and Younger Individuals	19%
Others	3%

*Based on a sampling of 19 of the 24 Local Mini-conferences and rounded off to the nearest percent.

APPENDIX A

When designing the suggested format for these conferences, NCOA hoped that the policy recommendations and the workshops themselves would serve as a stimulus for continuing local efforts to improve linkages between the young and old. In most communities, this objective has clearly been achieved.

During October 1980, a representative from each of the community workshops was invited to attend one of three regional meetings to analyze and synthesize the results from the local conferences. The implications of these recommendations were also examined in terms of the various technical committees of the White House Conference on Aging. The results of the three regional meetings were compiled by NCOA and sent back to the regional representatives to affirm that the outcomes of the synthesis process still accurately represented the sentiments of the participants in the local meetings.

On December 5, 1980, a national conference was held in Washington, D. C. to discuss the policy recommendations that had emerged and to examine strategic options for maximizing the impact of conference findings. Attending this meeting was approximately 35 experts from a variety of fields including aging, education, youth affairs, family, housing, religion, and social services. Two weeks after the meeting, a draft of the final report was sent to the national conference participants who were given a final opportunity for review and comment. The report was then forwarded to the White House Conference on Aging.

APPENDIX B

ACKNOWLEDGEMENTS

NCOA would like to acknowledge the many individuals who have contributed their time, energy and commitment to the development of this publication. Everyone who has been involved in the WHCoA Mini-conference on Intergenerational Cooperation and Exchange has done so at their own expense. We are grateful for everyone's contribution to a successful outcome.

Particular appreciation is extended to Beverly Brumbaugh and Pamela Shampan who provided limitless time and effort in implementing the many stages of the Mini-conference process. Laurie Sands and Sandy Nathan of ACTION's national office were also of great help to the project.

The Mini-conference could not have been undertaken at all without the work of the conveners and the participants in each of the 24 communities who were brought together to discuss intergenerational cooperation and exchange (see map on the next page).

Many thanks to the participants at the regional meetings who helped analyze and synthesize the results of the local conferences:

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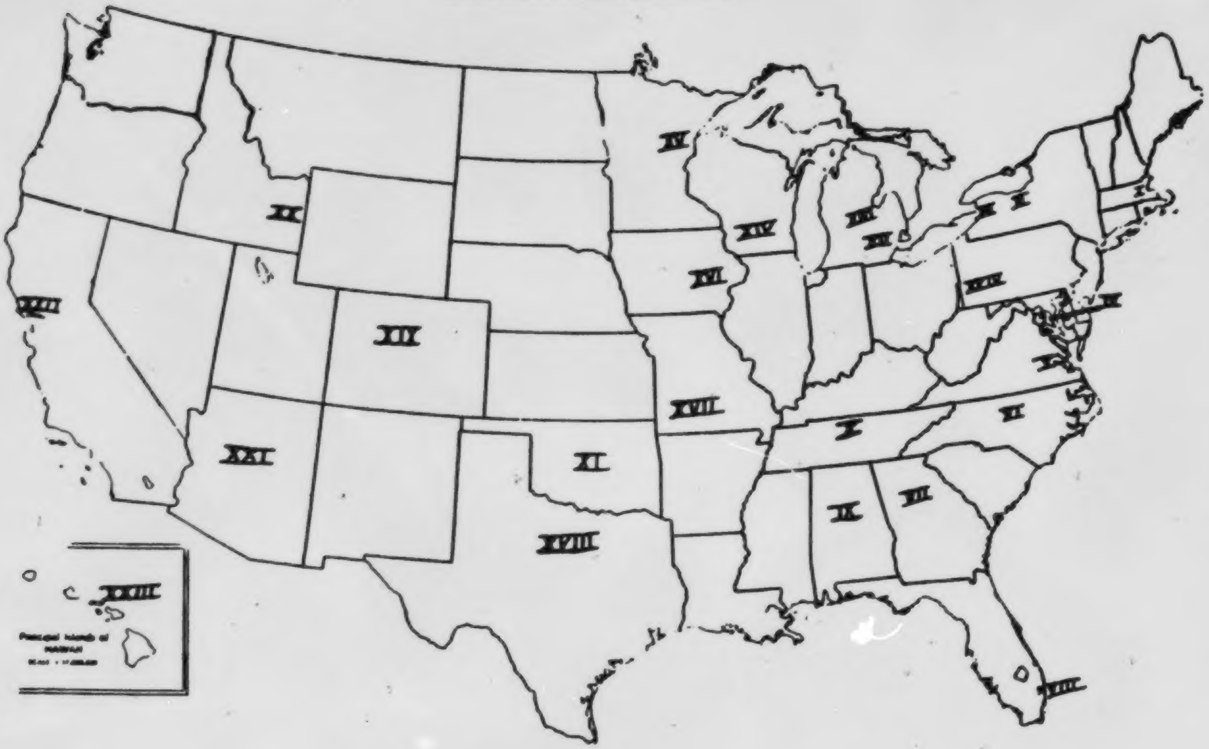
WHITE HOUSE CONFERENCE ON AGING MINI-CONFERENCE: INTERGENERATIONAL COOPERATION & EXCHANGE

LOCATION OF COMMUNITY WORKSHOPS*



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the 1981
White House
Conference
on
Aging

Report of the Mini-Conference on Life-Long Learning for Self-Sufficiency

MCR-12

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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BACKGROUND

The White House Conference on Aging, Presidentially-authorized on October 18, 1978, is designed to draw national attention to the growing number of older Americans, and the policies needed to maximize the resources and meet the needs of this important segment of the population.

In order that specialized issues are not overlooked, the White House Conference has authorized selected mini-conferences. These mini-conferences gave special attention to select issues identified by the Conference staff. One of these issues is lifelong learning.

The decade of the seventies produced a proliferation of material on education and aging. But most of this material focused on education as self-enrichment. During that decade the primary piece of legislation focusing on lifelong learning was Title I-B of the Higher Education Act of 1976, referred to as the Mondale Act. The definition of lifelong learning in the Act was all-encompassing and reflective of the focus on self-enrichment. The Act was never funded, partially due to the political difficulties of funding self-enrichment programs.

Recently, a trend toward programs geared to self-sufficiency has developed in the field of education and aging. This trend is reflected in research, publications and legislation, again through Title I of the Higher Education Act in the 1981 Reauthorization. The new focus of the Act is on adults (including older adults) whose educational needs have been inadequately served. It is hoped that these persons will develop greater self-sufficiency under programs funded through this Act.

Since there has been a shift in educational programming for older adults from self-enrichment to self-sufficiency, there is a need for a more systematic exploration of this area. This examination is of increasing importance, not only to the conferees of the White House Conference on Aging, but also to the 1982 World Assembly on the Elderly.

The mini-conference on Lifelong Learning for Self-Sufficiency was a cooperative effort involving four co-sponsoring organizations:

- Institute of Lifetime Learning of the National Retired Teachers Association-American Association of Retired Persons
- Commission on Education for Aging of the Adult Education Association/USA
- Association for Gerontology in Higher Education
- Population Resource Center

The Johnson Foundation awarded a grant which provided not only the Foundation's Wingspread Conference Center, but also its extremely capable Conference staff. Additional support from the American Association of Community and Junior Colleges made possible the preparation of this report.

The purpose of the mini-conference was to provide a forum for a group of experts, knowledgeable in the fields of education and aging, to identify and discuss key issues in lifelong learning particularly as they relate to an aging society. The ultimate goal of the mini-conference was to develop this report reflecting the policy and program recommendations for consideration by the committees, staff and delegates of the 1981 White House Conference on Aging. A secondary goal was to discuss and disseminate the materials on a broader scale through congressional hearings, presentations at national meetings, and distribution of supplemental papers.

The theme of the mini-conference was "Lifelong Learning for Self-Sufficiency." It considered a new policy thrust for the 1980s: focusing on how education can help older persons solve some of the problems they experience in their later years. The important "multiplier factor" of education was addressed: how can education enable older persons to move into productive roles which will, in turn, have positive economic and social effects on society as a whole.

There were four issues discussed under this broad theme.

- Surviving: Learning for Economic Sufficiency
- Coping: Learning for Practical Life Skills
- Giving: Learning for Community Contribution
- Growing: Learning and Life-Span Development

To assure that the conference identified the relevant issues, decided on their priority, and formulated careful recommendations, an unusually rigorous discussion-process was followed. The result was that, while still at Wingspread, the conferees had an opportunity to review the initial draft of this report, and make corrections and suggestions for revision. Thus, this document presents a validated synthesis of the conferees' deliberations, conclusions, and recommendations.

The Conference synthesizer and author of this official report was Ronald Gross, author of The New Old: Struggling for Decent Aging and The Lifelong Learner, founder-director of Writers in the Public Interest, and senior consultant to the Office of Adult Learning Services at the College Board in New York City. The Conference administration and coordination was handled by the Institute of Lifetime Learning of the National Retired Teachers Association and the American Association of Retired Persons.

I. LIFELONG LEARNING FOR SELF-SUFFICIENCY

Lifelong learning for self-sufficiency is a necessity, if we seek to accomplish the goals for Older Americans which are the target of the White House Conference on Aging.

Most of the major problems in the lives of older people on which the conference focuses -- economic security, physical and mental health, social well-being, and using older people as a national resource -- can be addressed effectively by learning which gives older people the capacity to deal with them. Education is the neglected necessity in dealing with these basic needs of older people.

But our entire system of education in America has always been centered on children and youth. Lifelong learning, except for a few triumphant examples such as the assimilation of immigrants, agricultural extension, and the public library system, has been an afterthought.

Now, however, with this nation very rapidly aging in its demographic profile, it is time to rectify what has become an imbalance. Lifelong learning for adults, and particularly for those older Americans who have so generously encouraged and funded the education of succeeding, younger generations, now deserves and needs increased attention, cultivation, and support.

Much has already been accomplished. The rates of participation of older adults in education have increased significantly. Many institutions have entered the field with a wide range of useful offerings. Attention has begun to be paid by government at the federal, state, and local level; by foundations and non-profit associations; by colleges, community colleges, and universities; by business and industry; and by other sectors of our society.

Moreover, research and experimentation now enable us to say with complete assurance that the myth that "You can't teach an old dog new tricks" is false and dangerous. Older people can learn effectively, enjoyably, and profitably.

Yet despite this progress, there is still far to go -- which is the reason for this paper. The older adults who benefit from all the new programs tend to be those who are already advantaged, educationally and economically. The vast majority of those most in need, are still unreached. Much of the education offered for older people is not relevant as it should be to their most pressing needs. Too much of it is conveyed in traditional forms, through conventional teaching in a classroom, rather than in a diversity of modes, formats, and styles.

In short, lifelong learning for older adults is a demonstrable reality today. But there is too little, it reaches too few of those who need it the most, and it is often too traditional in content and method.

Obviously, by lifelong learning we mean education in a new sense -- but one that is very close to each of our personal experiences. We do not mean merely the study of academic subjects in a classroom. We do not mean following a set curriculum of a school or college simply to obtain a degree. We do not mean being taught as a recreational activity to absorb too much leisure time.

Rather, we propose learning experiences that strengthen, enlarge, and enhance older persons' capacities to deal with the major problems of their lives, individually and in concert with others. The kinds of education we believe so essential include:

- Surviving -- learning for economic sufficiency (Sec. II)
- Coping -- learning for practical life skills (Sec. III)
- Giving -- learning for community contribution (Sec. IV)
- Growing -- learning for becoming a fuller human being (Sec. V)

How would such education help older Americans solve some of their major problems?

- Learning for economic sufficiency -- for finding satisfactory employment -- would give older people the option to augment their income, enhance their feeling of well-being, and contribute to society. Successful job-hunting and career development at any age require the learned abilities to assess and present one's capacities developed over a lifetime, to find and explore the full range of ways to earn money, to work effectively in new environments, and to acquire new marketable skills.

- Learning of practical life skills or restructuring of coping skills developed over a lifetime, would enable older persons to cope flexibly and resourcefully with their daily problems. Many older adults need better information and referrals to educational opportunities, awareness of the values of further education, peer counseling, basic education, and a feeling that they can obtain for themselves the learning they require.

- Learning for community participation could empower older people to help the nation cope with its mounting social and economic problems, while giving them a more creative role in society. They could identify problems, marshall resources to solve them, make institutions more responsive to human needs, and join with others in collective action

- Learning for becoming a fuller human being could give older Americans an authentic opportunity to make their later years the capstone of their lives, and proclaim to the rest of us why that period of life deserves respect. Older people would derive immense personal satisfaction if liberated for creative engagement with others.

Clearly, these are not the kinds of learning which go on only in schools and colleges. They can, do, and should go on in community organizations, senior centers, churches, libraries, homes, business offices and industrial plants. Our focus is not on finding new roles for formal educational institutions, per se, though such institutions have a crucial role to play in providing the opportunities we seek. Our focus is on the basic needs of older Americans, and how those needs might best be met through learning, wherever it occurs, by whomever it is facilitated, and under whatever auspices.

STRATEGIES FOR STRENGTHENING LIFELONG LEARNING FOR SELF-SUFFICIENCY

Nine basic strategies were recommended by conference work-groups addressing quite different issues, suggesting that together those strategies might constitute the basis for an overall program to strengthen lifelong learning for self-sufficiency. Those nine strategies were:

- Empower older people themselves to obtain better responsiveness from institutions, and to meet their own needs, wherever possible. Self-help, peer group counseling, advocacy efforts, and other means were proposed by which needs could be met by elders themselves. The capacity of elders to effect constructive change might well improve the quality of life for all Americans.

- Use existing institutions, programs, and resources to provide needed services and support, wherever possible. Simply by removing barriers to older peoples' participation in existing programs, for example, many could be served in useful ways. Improved coordination, cooperation, collaboration, and access could also make valuable experiences broadly available.

- Provide information, counseling and support services. Older people need help in making the best use of available opportunities, and in developing new ones. Most work-groups called for various kinds of services to provide the knowledge, understanding, and skills they need.

- Change negative laws, policies, regulations, or practices. Most work-groups cited examples of current provisions which act against the best interests of older people, ranging from government regulations on taxation and student aid, to some personnel policies in private industry.

- Begin earlier. Several of the groups noted the need to start in mid-life and even earlier, to prepare individuals for competent and constructive aging. Pre-retirement planning must begin at mid-career, for example, and positive images of the old should be a part of the school and college curriculum.

- Target some programs to meet the needs of the disadvantaged. Throughout the discussion there was continued emphasis on finding ways to help those with special or unmet needs. In some areas, such as job retraining, women were considered in need of special attention; in others, the poor or minority groups.

- Increase public understanding of the problems and potentialities of older people. Virtually every group noted the need for such heightened awareness, in the population at large, as well as among key professionals and practitioners. Both knowledge and understanding must be disseminated, the conferees urged, and many means were recommended, from the media to professional training programs.

- Conduct relevant research. New knowledge and understanding are needed to discover better ways to meet high-priority needs or solve pressing problems. Most groups acknowledged that much remains to be investigated and developed in this field.

- Alleviate economic barriers to learning for self-sufficiency. Most of the groups recommended some subventions to enable older people to become more self-sufficient. Government aid was generally seen as necessary in those areas where other means cannot assure that those most in need will receive the services they require.

II. SURVIVING: Learning For Economic Sufficiency

Of the four conference themes, this one reflects most sharply the changed economic and social climate in the U.S. since the 1971 White House Conference. Clearly, our new national awareness of economic constraints commands that we pay greater attention to the education and re-education of older persons for employment, as documented in the background paper by Pauline Ragan, Director of the National Policy Center on Employment and Retirement at the University of Southern California.

This area has been the most neglected in prior discussions of education for older persons. Yet work's central role in the lives of Americans should have suggested that even for older people, the option to work is important. As Dr. Ragan put it with admirable balance: "The intent is not to promote mandatory employment instead of mandatory retirement. Rather, the key is in promoting flexibility of the system so that older persons will have real options for work or retirement."

The demographic and economic pressures which compel attention to preparing older adults for employment are convincing:

- the cost of paying for retirement is becoming more severe because of the greater numbers of older people who retire earlier and live longer.
- the individual older person needs to be in the labor force longer because of his or her lengthened life expectancy and and the effect of inflation on retirement income.
- many employers need new older workers or need to retain current workers beyond the usual time of retirement.
- many older people would prefer to continue to work because of their attitudes, values, and sense of what's worth doing in life.

In short, as Dr. Ragan concluded, "economic and demographic trends make it costlier to the nation, the employer, and the individual to continue the current pattern of early and full retirement." The revitalization of the American economy could benefit significantly from the input of older workers, just as it should benefit sharply from the infusion of cadres of women and minorities. In all these cases, however, the pay-off hinges on the adequate education of these new workers to the point where they are maximally productive.

Women re-entering the work-force call for special attention, Dr. Ragan noted sharply, and more than technical training is required to equip them. Confidence-building, networking, and other attitudes and skills need to be developed.

The possible sources of education for older people include formal educational institutions, labor organizations, employers, and federal government programs. Here, Dr. Ragan concluded that the major opportunity for older workers to obtain the educational services they need, is through employers.

CONFERENCE RECOMMENDATIONS ON ECONOMIC SUFFICIENCY

o Incentives for the Private Sector

1. A comprehensive study should be undertaken by appropriate governmental agencies and the private sector to determine the ways in which the private sector can be encouraged to provide such training and education, and the advantages and disadvantages of each, as well as the costs.

2. The Federal and state governments should eliminate taxes imposed on employees on the basis of tuition benefits granted by employers.

3. Additionally, tax incentives for employers based on specific education and training programs should be developed to encourage training of older workers which would otherwise not be provided.

o Counseling and Support Services for Life Planning

4. Cooperative efforts should be encouraged among government, industry, institutions of higher education, unions, and community schools, to provide needed counseling and support services.

5. Information should be gathered and made available locally to older people about the job market. Data collection systems should be improved, to identify emerging employment needs and employment desires of older workers.

6. Training in counseling techniques should be provided. Services should be available to enhance job-finding skills.

7. Senior executives should be available on a 'loan basis' to gather information on local labor markets.

8. The special needs of older women and the disadvantaged should be recognized in the development of counseling programs.

9. Technical assistance should be provided to employers on how best to respond to the needs of older employees for encouragement, guidance, and support.

o Education for Older Adults for New Jobs and/or Job Retention

10. A "Senior Job Corp" should be established.

11. Cooperative endeavors should be encouraged between business/industry and educational or community organizations with emphasis on serving older adults.

12. Education should be provided for the middle-age period of workers' careers.

13. A percentage of each state's grant under the Adult Education Act should be set aside for upgrading the education of older workers. CETA legislation and guidelines for the Vocational Education Act's state-administered funds should be revised to reflect a similar focus.

14. Information about programs that have been successful in extending basic education to older adults should be disseminated.

15. Employers should be encouraged to provide released time so that qualified employees can take advantage of these basic educational services.

- Public Advocacy About the Economic Problems of Older Workers

16. A public information program should be undertaken to inform older people about issues related to public policy on work and retirement. Special attention should focus on the vulnerability of the Social Security system and the danger of reduced entitlements, which could coerce older workers to remain in the labor force beyond their desire or capacity to do so.

17. Information should be disseminated to the general public on these issues, engaging the mass media to reach the largest possible audience in a collaborative effort among the public and private sectors, foundations, unions, institutions of higher learning, and community agencies.

- Greater Intergenerational Understanding and Cooperation in the Workplace

18. A comprehensive study of the issues related to intergenerational work should be undertaken.

19. The use of older workers should be emphasized, where appropriate, to help train younger workers.

20. Intergenerational workshops should be offered, in which tensions can be candidly discussed in order to change behavior positively.

21. Training sessions for management on dealing with an older workforce should be provided.

(section continues)

- Responsive Education-Work Policies Within the Private Sector

22. Pre-retirement seminars should be encouraged for all middle-aged and older workers.

23. Personnel policies which encourage job step-down as a retention policy should be explored.

24. Phased retirement should be considered.

III. COPING: Learning for Practical Life Skills

We Americans are pre-occupied with acquiring coping skills. "How-to" books now constitute a large proportion of all books published and sold in the United States every year, and articles on such subjects have become the staple of every major consumer magazine.

But superficially understood and practiced, coping skills can conduce to defeat rather than success. In his background paper, David Demko, Director of Aging and Retirement Education at Delta College, University Center, Michigan, posed the problem: "What's the use in educating the aged to their greatest potential within a society that won't permit them to self-actualize?"

This question -- what is truly "practical?" -- has always been a difficult one in American culture. From Emerson's essay on Self-Reliance to the present day, the question has haunted us: What are the limits of individualism -- the degree to which the individual can indeed create his or her own success, regardless of the societal constraints?

Demko helpfully identified the major such barriers: the economic barrier, the mobility barrier, psychological barriers, and social barriers. He described what a congenial learning environment would be for older people: "Emphasis must be placed on eliminating the older adult's stereotyped perception of education as they experienced it in their youth. Educational programs such as course offerings and community services should be practical and informative so that the older learner can apply the information to his day-to-day living situation. Programs should utilize informal group discussion techniques in order to allow the older learner to participate as both a receiver of information and provider of information through sharing of meaningful past life experiences. Programs should be supportive in nature and stress the individual's capacity for self-help by showing how new information can be used in conjunction with the personal resources already possessed by the older adult. Programs should be flexible in length in order to allow the older learner to sample coursework before making a commitment for an entire semester. Weekend programs and short term residential institutes have proved to be quite popular as a sampling tool for the older population."

With such environments, Demko goes on to recommend, there is need to go beyond the usual array of coping skills. "The adult's generalizable coping skills must be enhanced so that he/she becomes an 'adaptor' to changes of all sorts. For example...successful adaptation to life crises (has been found) to be linked to the individual's ability to maintain a coherent and consistent self-image. Examples of generalizable coping skills are personal growth, assertion training, decision-making skills, and so forth...Preventive education, as currently practiced, is well received by the elderly since it assists them in coping with specific problems of everyday living. However, in addition to present efforts, educators should attend to the provision of generalizable coping skills which will render the older adult to be an 'adaptor' of all sorts. The greater issues lie beyond topical concerns."

"The Aging Education Continuum" is Dr. Demko's useful construct to visualize the range of offerings and services needed by older adults. "It ranges from better access to existing services, education for the elderly, education about the elderly, and the development of new knowledge. Services heretofore considered as 'outside the domain of education' may of necessity become part of conventional practice."

Demko calls for new strategies for intervention, alternate models for empowering older adults, models which exist but are not widely used. These strategies would be more proactive and diverse, taking us far from the prevailing norm of classroom instruction in leisure-oriented subjects.

Education, then, has a dual role in the development of coping skills: improvement of basic skills associated with functional competency, and expansion of more generalized skills for total fitness.

There is a clear need for educational services to bolster specific skills such as literacy and computation abilities which permit older Americans to function effectively in society, as well as topical educational programs focusing on health, retirement planning, etc. However, there are dangers to a highly specialized, categorical approach to the educational needs of the elderly. A more comprehensive, holistic consideration of their problems is needed to balance specific and generalizable skills.

In addressing this dual nature of educational coping services, three major principles were affirmed by the conferees:

First, particularly during a time of scarce resources, a high priority should be placed on the utilization of existing services to meet the coping needs of older Americans through the removal of barriers,and expansion of access to educational opportunities. These barriers include financial obstacles, lack of information and transportation, and structural barriers.

Secondly, self-help strategies should be used in educational coping services. Participation of the elderly in program planning, development and implementation is important.

Finally, there is a need for long-range responses to coping problems through the development of preventive coping services, especially pre-retirement education and life planning initiatives to prepare younger Americans for the problems associated with the aging process.

We know too little about the real coping needs of older Americans. There is a pressing need for the development of new knowledge through research and development efforts as well as the extension of existing models for the provision of generalizable coping skills.

CONFERENCE RECOMMENDATIONS ON COPING

o Empowerment Strategies

1. Efforts to meet the educational needs of the elderly should include providing them with the skills to identify their needs and to organize political and social pressure to attain them. These efforts should be encouraged at the local level through a range of community institutions.

o Removal of Barriers and Expansion of Access

2. Communications programs should convey to older adults the range of possibilities to participate in continuing education through such means as Elderhostel, peer counseling, and information and utilization of the "aging network."

3. Older adults should be reached with educational programs in their homes, via electronic media and other innovative techniques, by the public (Public Broadcasting Service and others) and private sectors.

4. Comprehensive information/referral programs for the elderly and their families should be instituted in every community.

5. Research should be conducted on structural barriers which impede older persons' educational opportunities, such as inappropriate curricula, scheduling, and teaching methods.

o Coping for Total Fitness

6. Since many older people have multiple problems, it is important that educational coping programs take a holistic approach.

7. Educators must raise their awareness, as well as the awareness of both older adults and service providers, about the need for integration and coordination of services.

- Generalized Coping Skills

8. Research is needed to develop new knowledge about generalized coping skills, such as decision-making, problem-solving, etc.

9. Existing models which provide generalized coping skills should be disseminated and replicated.

- Preventive Coping

10. Employers, both private and public, and unions should actively recruit their employees and provide a broad range of life planning programs to them long before retirement. These programs should include spouses.

- Functional Competency

11. Incentives should be provided to encourage educational institutions (including libraries, community programs, etc.) to offer basic education for older adults and to remove all barriers which prevent adults from achieving basic skills.

12. Programs for older adults designed to impart specific coping skills should utilize peer group strategies, as do models in tax education, mental health, and widowhood counselling.

- Public Subsidy

13. Education for older adults, broadly conceived to include both traditional and non-traditional forms, should be subsidized by the public sector on an on-going basis (as is education for youth), including student financial aid.

IV. GIVING: Learning for Community Contribution

Older Americans have begun to take new roles in their communities and in our society -- roles which reveal how much they have to offer and how well they can learn and teach the rest of us. Most of these activities are locally conceived and conducted, in true grass-roots fashion. Helen Kelley, Director of Older Americans Volunteer Programs at ACTION, evoked them in her background paper, and indicated why they are of such value to the individuals involved, and to the communities they serve: "It is neither possible nor necessary to catalog the myriad ways in which older people are learning to gain and maintain charge of the conditions of their lives. Neither will it be possible to identify and even less to institutionalize all the ways and places in which they are learning what they need to know to accomplish this control. Much of it is from memory released by leisure. Most of it is learned informally: a conversation in the local bar; a visit to an old friend in a nursing home; observing that their grandchildren or great grandchildren can't read well; getting a notice that their apartment is going condo or that the rent is going up by 75%; receiving the utility bill; hearing an astute editorial on TV or radio; attending, perhaps out of boredom, a lecture in the church or union hall or senior center which suggested forcibly that there were ways to take charge that might benefit everyone -- or at least, almost everyone. "

The federal government has supported some highly successful nationwide efforts along these lines. VISTA (now administered by ACTION), in its fifteen years of existence, has supported among other things the work of volunteers over 55 years of age, who have created hundreds of self-help organizations which advocate for improved services; establish craft, farm and consumer cooperatives; form tenant associations; create nursing home ombudsman programs; assure access for the handicapped to benefits due them; and provide day care to the children of the poor. ACTION also administers the Retired Senior Volunteer Program, the Foster Grandparent Program and the Senior Companion Program.

On the basis of what has been accomplished in these programs and the many more conducted without public subvention, Kelley observed that "the resources for lifelong learning exist in every school house, college and university; in every church and temple; in every legislative hall no matter how small or how large; in every radio and television station; in every library, hospital or clinic; in non-profit organizations literally too numerous even to list. Each of them is, in some sense, in the public domain, either by reason of explicit law or tax support or tax exemption. If some of them are not hospitable or inviting, there are already ways of helping them to be more responsive."

Kelley asserted the need for leadership and support if such activities are to further flourish: "Since we live in a managed society, it is foolhardy to expect that older people will step up individually and hawk their wares, so to speak. Institutions of leadership and support are needed if we are to institutionalize healthier and self-fulfilling expectations of what it means to be older. Fortunately, a number of such institutions and movements already exist."

However, she concluded that it may be premature or inadvisable to "wrap public policy" around these developments. "A lifetime of surviving, coping and growing is, in itself, a profound learning experience. Perhaps we shouldn't try to institutionalize it or wrap public policy around it. The networks of service and advocacy which are being formed by and on behalf of older people may not yet, I fear, be strong enough to bear the weight of a public policy. Let their thousand flowers bloom."

CONFERENCE RECOMMENDATIONS ON GIVING

- Laws, procedures and policies which discourage participation by elders.

1. IRS regulations currently penalize non-job-related retraining for later careers. They should be changed to encourage education providing opportunities for giving by elders.

2. Personnel regulations in the public and private sectors, and union-management contracts, often discourage individuals from continuing their development. Such regulations should instead encourage personal and professional growth through provision of educational leaves or job sharing by elders.

3. Federal and state student loans and grants should be extended to older students.

4. State legislatures should initiate programs of reimbursement or direct funding to public secondary schools, colleges, and universities that offer continuing career training for elders, and such students should be included in computing FTEs (full-time equivalent students).

5. Age discrimination policies in educational institutions and agencies should be identified and eliminated.

6. Demonstration projects to design, test, and disseminate selected retraining programs should be funded by government or private foundations, or by business or industry.

7. Educational institutions should relate to the total learning life of adults, not just the 18-22 age group.

8. Federally-funded Education Opportunity Centers should receive expanded funding.

9. Education in non-traditional settings and subjects should be expanded

- Attitudes about the potential of the elderly to contribute to our society

10. Unions and trade associations should be encouraged to offer their retirees opportunities for continued involvement.

11. Media communicators should be educated to change their attitudes about the potential of the elderly, and help influence public perceptions of the elderly.

12. General education at all levels should include the positive aspects of aging and the potential contributions of older persons.

13. The continuing education of practitioneers and professionals should include the contributory roles of older people.

14. Inter-generational programs on the local level should be developed, including models that stress the positive potential of older persons as contributors to our society.

15. Attitudinal research to identify successful approaches to creating a more positive image of the potential role of the elderly should be encouraged.

- Receptivity of institutional systems to contributions of older persons

16. Governance structures and policies of public and private organizations should be reshaped to affirmatively involve older citizens (e.g. boards, committees, planning bodies, etc.)

17. Management planning and policy within organizations should facilitate on-going contributions of older personnel (e.g. job restructuring; flexible work schedules; volunteer board, committee or consultant roles, to reflect continuing interest and fields of expertise supported by continuing education).

18. Advocacy efforts utilizing time, energy and talents of older persons, addressed at social change goals, should be recognized as a legitimate special political interest encouraged as beneficial to an aging society.

19. In-service training and education programs should sensitize professionals to the potential contributions of older persons.

20. Educational programs for administrators and managers, regarding age discrimination laws and issues, should be encouraged and supported.

21. As public responsibilities shift to the private sector, the resources of older persons must be utilized.

- Legitimation of the contributions of older volunteers

22. ACTION'S Older Americans Volunteer Programs, which have demonstrated the will and ability of older people to contribute significant service in their communities, should be expanded.

23. Current policies and practices of volunteer-using agencies, in respect to their utilization of older people, should be rigorously reappraised.

24. Training for volunteer work, and participation in it, should be considered as legitimate experience for older persons.

- Contributions/Giving from Special Groups of Older Persons

25. Grass-roots, self-help, volunteer, and culturally relevant programs should be identified and provided with technical assistance and financial support in order to expand their opportunity to contribute to the community.

26. Training opportunities should be provided at the community level to assist these special groups to understand the financial and social structure of their communities, to help them make a more significant contribution.

27. Media projects and model or demonstration programs should be supported and implemented, which reflect the contributive role of these special groups.

28. Economic counterparts to tax shelters for the rich should be available to the poor to encourage on-going learning and giving.

29. Community recognition and rewards systems and programs should be financed and encouraged at the local level to recognize the contributions from special groups.

Note: A dissenting viewpoint on the issue of volunteerism was expressed by Dean Robert Lewis Piper of Southeastern Massachusetts University. Urging more careful examination of the whole concept of volunteerism, Dean Piper pointed out that it is closely associated with the aristocratic idea of *noblesse oblige*, and is therefore based on a class structure; that it is becoming less tenable in an economic system offering wider ranges of employment to women, who have typically been the volunteers in American society; and finally that the concept is tainted with a racial bias since it has been dominated by Anglo Saxons. Therefore, Dean Piper concluded, a reexamination might well lead to eliminating this whole area from the consideration of elderly self-sufficiency. This viewpoint was strongly contested by other participants who endorsed volunteerism for older people.

V. GROWING: Learning and Lifespan Development

Is learning *per se*, as a good in itself, a legitimate concern of public policy in a democracy?

The distinguished American historian Howard Mumford Jones, reflecting on the Declaration of Independence's affirmation of man's right to "life, liberty, and the pursuit of happiness," points out that "the only durable meaning of 'life' in this context is one's inner life, the only use of 'liberty' is long-run freedom to enrich that inner life, and the only possible meaning of happiness lies in some less transient satisfaction than eating and drinking, getting and spending, and being amused."

Applied to learning by older adults, this conviction suggests that learning for personal growth towards the end of life is a good in itself. Older people would seem to both need and deserve such learning. The seers of classical Greece thought that the proper time to study some of the most profound and humanly important subjects was not in youth, when one lacks experience with the world and knowledge of life, but in later maturity. They believed that the most serious literature, the deepest philosophy, the most intricate political science, the subtlest explorations of oneself, were best undertaken by mature people.

Moreover, the fruits of such learning -- described as "changes in consciousness" in the background paper by Dr. Harry Moody, Director of the National Policy Study Center on Education, Leisure, and Continuing Opportunities (National Council on Aging) -- can turn out to have momentous practical consequences. While affirming that such growth is a good in itself and entirely justifiable for that reason, Moody pointed out that older people will be far better able to survive, to cope, and to give if they have benefitted from some of the values of such learning. They would be liberated from stereotypes that limit their view of what they could accomplish. They would understand far better the realities of other people and of the society. They would be able to articulate values and to act on them. Moody wrote: "When I speak of changing one's consciousness, I mean a reorientation of thinking that has immediate practical results for all my transactions with the world. 'Growing' is not the enjoyment of special states of consciousness but the mobilization of consciousness to see the world in a new way and then to act on the basis of a new way of seeing. Understood in this way, changing consciousness is the most practical step one can take.

I would emphasize, too, that this dimension of "growing" is precisely what underlies the ultimate effectiveness of lifelong learning in each of the other three domains: surviving, coping, and giving. Let me make this point clear by looking at the example of learning for economic survival. In lifelong learning for economic survival, what is needed is a shift of consciousness on the part of those older workers who seek employment in the labor market. Books such as What Color is Your Parachute? along with training programs for displaced homemakers all send the same message: Don't accept the negative self-image that whispers that you haven't got any skills. Most people through their life experience pick up any number of skills and knowledge that isn't sorted into categories and certified by labels and credentials. Part of self-sufficiency is the discovery that my life experience itself is a rich source of prior learning that can be adapted to new experiences and new demands, provided that I can learn to think of my skills and experience in a new way.

Both as a good in itself, then, and as the most practical kind of learning, Moody urged the support of opportunities here, by public and private policy. But he stressed that future funding should be sought not merely to provide more of what we already have, but to exert leadership, promote innovation, and encourage the kind of learning that goes deepest and makes the most ultimate difference in the quality of peoples' lives.

CONFERENCE RECOMMENDATIONS ON GROWING

- Public acceptance of the personal and social value of lifelong learning for growth

  1. Research and demonstrations should be undertaken which will indicate the tangible benefit of self-actualization activities for older persons.

  2. Negative expectations concerning older persons' abilities to continue to grow and develop must be overcome, and a positive view of aging should be fostered through legislation, social programs, media, and public information channels.

  3. Older adults should be provided opportunities to become politically literate in the techniques of obtaining and utilizing education for growth.

- Funds to underwrite lifelong learning

  4. A range of public, private, and voluntary funding streams, including self-provision, employer tuition remission toward preretirement education, tax-deductions for lifelong learning or a voucher system good for continuing education opportunities, should be employed in various combinations to encourage lifelong learning experiences.

- Self-directed lifelong learning

  5. The educational establishment should develop alternatives which encourage self-directed learning experiences throughout individuals' lifespans. Self-help, peer association and training, and self-actualization should be encouraged as means to self-concept improvement and involvement.

  6. The educational establishment should recognize the fact that older persons' learning ability and motivation to learn are affected by their past educational experiences and that such motivation is potentially an educable disposition; therefore, educational programs should include orientation to such awareness and systematic effort to generate motivation to continue educational pursuit throughout life.

- Lifespan education

  7. Education about aging, for aging, and the need for lifelong learning to deal with critical life issues should be made an integral part of the school curriculum.

8. Because of the lack of preparedness of many professionals to deal with their own adulthood and with that of the persons whom they serve, curricula for professionals (for example, educators, service providers, clergy) should include knowledge about normal adult development and about the skills necessary for helping adults negotiate normal life changes.

- Diffusion of innovation, utilization and dissemination

9. A central information agency should set up a clearinghouse and data base for information on lifelong learning, perhaps through some appropriate existing agency with a relevant mission.

10. Results of basic and applied research and demonstration projects on adult lifespan development and aging should be disseminated at national and local levels.

11. Regional and local units on aging should include lifelong learning projects in their area plans.

- Meeting the needs of the least advantaged

12. This group should be targeted in all educational legislation and regulations.

13. The private sector, business and industry should be encouraged to serve the least advantaged.

14. Maximum and effective exploitation of the expanding telecommunications technology should be utilized as the means of disseminating information and education for less mobile constituents.

15. A system of elders' advocates should be established through the voluntary sector to identify the least-advantaged older persons in each community.

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the 1981
White House
Conference
on
Aging

Report of the Mini-Conference on the Arts, the Humanities and the Older Americans

MCR-13

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

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INTRODUCTION

On February 1-3, 1981, the National Council on the Aging (NCOA) convened a Policy Symposium on the Arts, the Humanities and Older Americans to make policy recommendations concerning ways that the arts and humanities give meaning and importance to the lives of our nation's elders and that they, in turn, contribute to the cultural life of the country. Held in Philadelphia, the Symposium was sponsored by the National Endowment for the Humanities and the National Endowment for the Arts and was an officially sanctioned mini-conference for the 1981 White House Conference on Aging.

The Symposium directly evolved from two developments: 1) NCOA's longstanding involvement in arts and humanities activities for and by older people and its advocacy for increased recognition of older Americans' role in the nation's cultural life; and 2) a Memorandum of Understanding among the National Endowment for the Arts, the National Endowment for the Humanities, the Administration on Aging and the White House Conference on Aging, signed on September 16, 1980. This interagency agreement outlined long-range plans for cooperation in the areas of the arts, humanities and aging of which the Symposium was a key initiative.

The Symposium had a three-fold purpose: 1) to deliberate issues and make recommendations for consideration at the 1981 White House Conference on Aging; 2) to build a broad foundation and framework for mutually supportive working relationships among humanities scholars, artists, and people in the field of aging; 3) to develop, through the publication of a volume gathering the products and conclusions of the Symposium, a future agenda for the arts and the humanities as they relate to older people and to aging.

A ten-member steering committee was created to oversee and help plan the Symposium. The following artists, humanities scholars and specialists in aging comprised the committee's membership: W. Andrew Achenbaum, historian, Carnegie-Mellon University; Lew Ayres, actor and lecturer, representative of the Screen Actors Guild; Willard L. Boyd, President, University of Iowa, and member, National Council on the Arts; Dr. Robert N. Butler, Director, National Institute on Aging, and Honorary Chair of the Symposium Steering Committee; Selma Burke, sculptor, New Hope, Pennsylvania; Ronald Gottesman, Director, Center for the Humanities, University of Southern California; Nancy Hanks, member, White House Conference on Aging Advisory Committee, Washington, D.C; Harry R. Moody, philosopher and Director of Academic Affairs, Brookdale Center on Aging, Hunter College; Billy Taylor, jazz musician and composer, New York; and Carolyn E. Setlow, Vice-President, Director of Corporate Planning, Newsweek, Inc., and Chair of the Symposium Steering Committee.

In preparation for the Symposium, NCOA, through its National Center on Arts and the Aging and Senior Center Humanities Program, called upon key leaders of arts and humanities programs to convene community forums addressing the creative, cultural and intellectual needs of older Americans. The response was immediate and enthusiastic. Working with an outline of suggested discussion topics, groups organized forums in senior centers, congregate meal sites, libraries, nursing homes, senior housing complexes and community colleges.

The reports and recommendations received from 57 different locations representing 21 states and the District of Columbia were synthesized and distributed to Symposium participants for consideration in their deliberations. A total of 3,112 persons took part in the forums from July through December 1980, the majority being older adults, but also including professionals in the aging field, university faculty, arts council members and state and local officials. What emerged from the forums was a vivid picture of the creative energy of countless older Americans and very strong testimony indicating that issues of life enrichment are of significant concern to them.

In further preparation for the Symposium, seven background papers were commissioned to help establish a direction, authority and framework for conferees' deliberations. The subjects covered were: "Aging and Cultural Policy;" "The Arts and Older Americans: A Progress Report;" "The Humanities and Aging America;" "Older Americans and the Arts: Analysis of Current Survey Findings;" "Report on Arts and Humanities Community Forums;" "Japanese Arts and the Aging: A Living Tradition;" and "Arts and Minorities."

Eighty-two artists, humanities scholars, specialists in aging and older persons involved in arts and humanities programs attended the Symposium at the invitation of NCOA acting on the advice of the Symposium Steering Committee. Originating from 25 states and the District of Columbia, participants represented diverse backgrounds, interests and groups. They were divided into small working groups, each with a facilitator and rapporteur, and intermittently shared collective findings and recommendations at regularly scheduled plenary sessions. On the final day of the Symposium they reviewed a published collection of issues and recommendations emanating from all groups, refined them, identified gaps and then prioritized recommendations.

The overwhelming sense of the Symposium was that the arts and humanities contribute as much to the vitality and well-being of the nation and its citizens, including older Americans, as other activities often deemed more essential to physical survival. The following Preamble, drafted by Symposium participants, states the assumptions and goals underlying present and future policies for the arts, the humanities and aging.

PREAMBLE TO SYMPOSIUM RECOMMENDATIONS

The arts and humanities, repositories of our cultural heritage, offer perspectives, traditions and aesthetic achievements in which elders, like all others, can find opportunities for expression and for learning. The creation, understanding and transmission of art and knowledge make life more than a matter of physical survival--more, in Yeats' words, than a "long preparation for something that never happens." The arts and the humanities enrich lives; they can be pursued in solitude and in company; they are common to peoples of all ages, sexes, races and creeds.

Therefore, the rights of older Americans to opportunities in the arts and humanities are co-equal with their rights to be well-fed, well-housed, and well-defended. Extending life without extending meaning to people's later years can be a cruel hoax. It must be national policy to recognize and support the rights of older people to discover fulfillment through the arts and humanities and to insure that they, no less than other age groups, be provided with opportunities for sharing, both as givers and receivers, the heritage they helped create and sustain in their younger years. Creation, expression, and learning must be seen as the functional equivalent of work.

The United States has for too long ignored the cultural needs and perspectives of its older citizens. The consequence is impoverishment of the lives of older people, whose creative potential remains unfulfilled, and of younger persons, whose knowledge of themselves and of others requires the memory and experiences of their elders.

To insure that the ideals in this Preamble are realized, the following recommendations and policies should be adopted by the Delegates to the White House Conference on Aging and by all public and private agencies involved in the arts, the humanities and aging.

I. OLDER AMERICANS' ROLES IN AND ACCESS TO THE ARTS AND HUMANITIES

No previous generation of older Americans has lived through such extensive socioeconomic changes resulting from major wars, technological innovations, new patterns of work and leisure, and population mobility. The elders of today constitute a unique link between rural, pre-electric society and the "post industrial" society. Regrettably, neither society nor even many older people recognize the significance of their experience and perspectives. This is a reflection and result of negative images of aging, affecting society in general and older persons in particular. Involvement in and access to the arts and humanities by today's and tomorrow's older Americans, both the impaired and the well, can help them make retirement a domain of meaning rather than an empty time and space and can also help them validate, explore and transmit the richness of a lifetime's experience as a link between the past, present and future.

RECOMMENDATIONS

I.1 Multiple Levels of Involvement of Older People in Cultural Programs

ALL PROGRAMS IN THE ARTS AND THE HUMANITIES FOR OLDER PEOPLE SHOULD PROVIDE, TO THE FULLEST EXTENT, OPPORTUNITIES FOR THEM TO EXERCISE THEIR TALENTS AND INTERESTS AS PROFESSIONAL ARTISTS, TRAINED AMATEURS, STUDENTS, SCHOLARS, CONSUMERS, PUBLIC INTERPRETERS, ADVISORS AND LEADERS.

Several possible action steps seem desirable:

- Include in funding stipulations to community organizations and programs the requirement that qualified older people, including older artists and humanities scholars, be actively sought and adequately utilized in the direction and implementation of all cultural programs and projects.
- Arts and humanities institutions and agencies, such as the state arts councils and humanities committees, should involve older individuals in advisory and policy-making roles to every extent possible.
- Aging and cultural organizations at the local, state, and national levels should establish and maintain "talent banks" for use in tapping the creative resources of older artists and humanities scholars.
- The arts, humanities and aging networks should develop and expand ways of addressing the needs and potential contributions of older Americans who have been denied full access to the arts and humanities in their younger years.
- Develop additional projects which demonstrate to more older people how engagement in the arts and humanities can contribute to their lives.

I.2 Promote Intergenerational Exchanges of Culture and Values

AGENCIES, PROGRAMS AND COMMUNITIES SHOULD PROMOTE AND DEVELOP OPPORTUNITIES FOR PEOPLE OF ALL AGES TO MEET AND EXCHANGE CULTURAL TRADITIONS, CREATIVE VISIONS, AND SKILLS.

Possible courses of action include:

- State arts councils and humanities committees should encourage the creation of individual or group apprenticeships to pair experienced older craftspeople with motivated youth in folk and decorative arts, and other aspects of our diverse cultural heritage.

- School systems should explore ways for older people to facilitate the transmission of cultural values and artistic talents to school age children.

- Encourage and support oral histories and autobiographical writings of older people in letters and in the fine and performing arts for transmission to younger generations.

I.3 Broaden Recognition of Older Creators in Arts and Humanities

THE MEDIA, CULTURAL AND EDUCATIONAL INSTITUTIONS, COMMUNITIES AND SOCIETY AT LARGE SHOULD HONOR IN SYMBOLIC WAYS THE ACCOMPLISHMENTS OF OLDER CREATORS IN THE ARTS AND HUMANITIES AS A STEP TO CORRECT "AGEISM."

Actions such as the following will advance this recommendation:

- Annual televised awards to distinguished older Americans who have made outstanding contributions to the nation's cultural life.

- Creation and showing of films and film strips depicting the lives and contributions of older people in the arts and humanities.

- Cultural and social service agencies in local communities should provide adequate facilities and opportunities for older creators in the arts and humanities to display, perform, or publish their works.

I.4 Special Needs of Handicapped Older Americans

ALL ARTS AND HUMANITIES PROGRAMS, PROJECTS AND EVENTS SHOULD PROVIDE GREATER ACCESS FOR IMPAIRED OLDER PERSONS.

The following action steps are suggested:

- Develop more model projects in aging which demonstrate the letter and spirit of the law stated in section 504 of the Rehabilitation Act of 1973.

- Involve physically handicapped older adults in planning arts and humanities programs for special audiences.

- Develop training workshops and other materials to help cultural service providers learn about a multiplicity of handicaps and develop programs to accommodate them.

- Encourage friendly visiting and visiting nurses programs to include specially designed arts and humanities projects in their services to the homebound elderly.

II. DEVELOPING LINKAGES AND EXPANDING NETWORKS

The multifaceted conceptual and programmatic connections among the arts, the humanities and aging need to be strengthened and made more mutually reinforcing. This can be accomplished by insuring that groups, institutions and segments of society subscribe to the goals expressed in the Preamble and by forging linkages and partnerships across a broad range of public and private organizations.

RECOMMENDATIONS

II.1 Governmental Linkages of Arts, Humanities, and Aging Activities

LOCAL, STATE, AND FEDERAL GOVERNMENTS SHOULD ESTABLISH FORMAL LINKS AMONG AGENCIES TO PROMOTE THE FUNCTION OF THE ARTS AND HUMANITIES IN IMPROVING THE QUALITY OF LIFE OF OLDER AMERICANS.

Several possible actions emerge from this recommendation:

- Implement to the fullest possible extent the recently consummated interagency agreement of cooperation among the Administration on Aging, the National Endowment for the Humanities, and the National Endowment for the Arts.
- Encourage states and localities to develop cooperative agreements similar to the federal model and to provisions included in the Older Californians Act of 1980.
- Establish an office or desk in an appropriate agency to coordinate efforts and disseminate information, among all governmental bodies having direct or indirect interests in the arts, the humanities, and older people.

II.2 Promotion of Arts and Humanities by Social Service Agencies

SOCIAL SERVICE AGENCIES, PARTICULARLY THOSE SERVING ELDERS, SHOULD INTEGRATE AND MAKE PARAMOUNT THE ROLE OF THE ARTS AND HUMANITIES IN IMPROVING THE QUALITY OF LIFE OF OLDER AMERICANS AND SHOULD ACTIVELY INVOLVE PROFESSIONAL ARTISTS AND HUMANITIES SCHOLARS IN THE CREATION AND OPERATION OF PROGRAMS.

Among other possibilities the following action steps are recommended:

- Extend more widely artist and humanist-in-residence programs at senior centers, nursing homes, or other facilities serving the needs of older people.
- Establish regular channels for liaison and cooperation among state arts and humanities councils, and area agencies on aging and state offices on aging.

- Offer aging service providers greater exposure to and training in arts and humanities programming either through demonstration sessions at appropriate meetings of state, regional and national associations in aging (e.g., National Association of State Units on Aging) or through specially convened training sessions at the local level.

II.3 Involving Labor and Business in the Arts, the Humanities and Aging

LABOR UNIONS, BUSINESSES, AND INDUSTRIES, MANY OF WHOM HAVE SUPPORTED VARIOUS ASPECTS OF THE ARTS AND HUMANITIES, SHOULD DEVOTE MORE ATTENTION AND RESOURCES TO SUPPORTING THE ENDEAVORS OF OLDER PEOPLE IN THESE FIELDS.

Labor and business can begin to implement this recommendation with several action steps:

- Recognize and utilize the contributions that the arts and humanities, especially through the services of retired or older Americans, can make to their ongoing purposes and activities.
- Hire older artists and humanities scholars to design specific life-enriching experiences as part of regular retirement preparation programs.
- Introduce arts and humanities programs and discussions directly into work situations or environments as a preparation for enriching people's life after work.
- Actively develop partnerships with local arts, humanities and aging agencies to seek new ways to involve older citizens in the cultural and intellectual life of their communities.

II.4 Linking Humanities, Arts and Aging in Institutions of Higher Education

INSTITUTIONS OF HIGHER EDUCATION SHOULD INTEGRATE TOPICS AND PERSPECTIVES OF THE ARTS AND THE HUMANITIES INTO GERONTOLOGY PROGRAMS AND SHOULD ALSO EXAMINE THEIR SERVICES AND CURRICULA IN THE ARTS AND HUMANITIES WITH A VIEW TO MAKING THEM MORE ACCESSIBLE TO OLDER PEOPLE OF ALL BACKGROUNDS.

To carry out this recommendation, postsecondary education institutions should:

- Utilize retired faculty in the arts and humanities to develop courses on and off campus for older adults.
- Endow chairs in the arts and humanities for retired professors to recognize their achievements and to encourage them to work with their peers.

- Require students in gerontology to take at least one course in the arts or humanities as specifically relate to aging.

II.5 Religious Groups and the Arts, the Humanities and Older Persons

RELIGIOUS BODIES, INDIVIDUAL CONGREGATIONS AS WELL AS ASSOCIATIONS, MUST RECOGNIZE THE IMPORTANCE OF OLDER PEOPLE'S CREATIVITY AND INTELLECTUAL PROWESS TO THE LIFE OF THEIR ORGANIZATIONS AND SEEK NEW WAYS TO PROMOTE CULTURAL CONTRIBUTIONS AND ACTIVITIES OF ELDERS.

The following actions are suggested:

- Encourage religious groups to return to historical precedents of commissioning and displaying works by older member artists and humanists in the group's facility.
- Involve older members in planning arts and humanities programs for the congregation as well as the community.

II.6 Linking the Medical Fields, the Arts, the Humanities and Older Persons

ARTS AND HUMANITIES NETWORKS SHOULD ESTABLISH FORMAL AND INFORMAL RELATIONSHIPS WITH MEDICAL, MENTAL HEALTH AND THERAPY AGENCIES AND ORGANIZATIONS TO PROMOTE BETTER UNDERSTANDING OF HOW THE ARTS AND THE HUMANITIES CAN ENRICH HEALTH CARE IN OLD AGE.

Several actions can be taken:

- Include representatives from medical disciplines in demonstrations, workshops, and seminars dealing with arts and the humanities as vehicles for communication among and socialization of older persons.
- Encourage use of older artists and humanists as advisors to health care agencies and organizations serving older adults. Promote inclusion of arts and humanities subject matter into scientific curricula used in training health care and medical personnel.
- Expose administrative and nursing staff of institutions housing vulnerable older persons to arts and humanities programs specifically designed for these populations.

II.7 Professional Associations in Arts and Humanities to Take Cognizance of Aging Issues

PROFESSIONAL ASSOCIATIONS IN THE ARTS AND HUMANITIES ON LOCAL, STATE AND NATIONAL LEVELS SHOULD TAKE GREATER COGNIZANCE OF AGING ISSUES AND WHEN PLANNING ACTIVITIES SHOULD CONSIDER THE INTERESTS OF OLDER ARTISTS AND HUMANITIES SCHOLARS AS WELL AS THOSE OF THE OLDER AMERICANS IN GENERAL.

By taking the following possible actions, professional associations can comply with this recommendation:

- Promote the elimination of negative stereotypes of the aging in school and college curricular materials.
- Encourage greater attention to aging and the concerns of older association members at conferences.
- Encourage use of older artists and humanities scholars as resources in schools and colleges.
- Champion increased involvement of the elderly in academic and cultural institutions.

III. ISSUES RELATING TO SOCIETY AS A WHOLE

The arts and humanities enrich our society in many ways, including: creating understanding among diverse social, ethnic, racial, and religious groups; combating negative attitudes and images about older people; and communicating visions of human values and creativity to society at large. Contemporary technology can help the arts and humanities serve some of these purposes, as can older people who can function as agents for cross-cultural understanding.

RECOMMENDATIONS

III. 1 Expand Cultural Programming on Radio and Television for Older People

BECAUSE MANY OLDER AMERICANS, PARTICULARLY THOSE LIVING IN ISOLATED CIRCUMSTANCES BY VIRTUE OF LOCATION OR ILL-HEALTH, DEPEND ON RADIO AND TELEVISION TO PROVIDE THE MAJOR AND SOMETIMES THE ONLY ACCESS TO THE ARTS AND HUMANITIES, BROADCAST MEDIA SHOULD FOCUS MORE ON THE CULTURAL NEEDS AND INTERESTS OF THEIR OLDER AUDIENCES.

Several courses of action are possible and desirable:

- In areas where cable franchises are to be awarded, franchisers should require cable operators to: 1) dedicate specific cable channels to programming of, by and for older Americans and provide the necessary financial and technical support for such programming produced locally; 2) provide regular programming that promotes active participation in and information about the arts and the humanities; and 3) maintain vigilance to insure that programming portrays accurate images of older people.
- In areas where cable television now exists, public agencies and private organizations should exert pressure to insure that the cable system delivers programming and information, particularly of a cultural nature, that reflects the interests of older Americans.

- The federal government should continue and increase funding of public radio and television to insure maximum access of all people, but particularly elders, to cultural programming and acitivities.

- Public and commercial telecommunication companies should pursue technological advances and develop programming formats that will actively engage homebound and institutionalized elders in arts and humanities activities.

III. 2 Role of Media in Combating Negative Attitudes Toward Aging

SINCE RADIO AND TELEVISION PLAY A DECISIVE ROLE IN SHAPING ATTITUDES TOWARD OLDER AMERICANS, THEY SHOULD BE PORTRAYED REALISTICALLY AND FAIRLY.

Among many possible actions to deal with this issue, two are particularly relevant to the arts and the humanities:

- Commercial and public broadcast media should employ more older actors, especially to take older character roles.

- Radio and television producers should develop programs about past and present older Americans in the arts and letters as a means of emphasizing the creative potential of older people.

III.3 A Need for Cross-Cultural Perspectives

ARTS AND HUMANITIES PROGRAMS THAT ARE MULTI-ETHNIC IN ORIENTATION, INVOLVE ELDERS WITH DIFFERENT ETHNIC AND CULTURAL TRADITIONS AND UTILIZE WORKS AND CREATIONS FROM THEIR DIVERSE HERITAGES SHOULD RECEIVE HIGH PRIORITY.

Possible courses of action include:

- Funding sources should insure that cultural programs for and by older Americans appeal to a broad mix of ethnic and racial groups and fully draw upon their creative visions and accomplishments.

- American Indian elders should be utilized more fully as a resource in educating the young as well as the non-Indian population.

IV. LEGISLATION AND GOVERNMENTAL ACTIVITIES

Changes in legislation, policies, and regulations of governments and institutions underlie many Symposium recommendations. The Symposium recommends several legislative amendments, strategies for implementing or funding present legislation, and proposals for various intiatives by the executive branch. Although the recommendations in this section relate to the federal government or national legislation, they are, for the most part, equally applicable to circumstances at state and local levels.

RECOMMENDATIONS

IV.1 Amendments to the Older Americans Act

WHEN THE OLDER AMERICANS ACT IS REAUTHORIZED, CONGRESS SHOULD MAKE AMENDMENTS INSURING THAT THE ARTS AND HUMANITIES ARE SPECIFICALLY RECOGNIZED AT ALL POSSIBLE AND APPROPRIATE PLACES IN THE LEGISLATION.

This recommendation calls for several specific actions:

- Include under title III (State and Community Programs in Aging) the term "cultural services" within the meaning of "social services," thereby making arts and humanities programs central to improving the quality of life for older Americans and eligible for funding.
- Include under title IVA (Training) provisions to sensitize and train service providers about the intellectual and cultural needs of older persons.
- Include in title V (Community Service Employment) the term "cultural services" within the meaning of "community services," in order to increase the use of this title for the training and employment of older artists and humanists, or of other older people, in cultural services.
- Add a separate authority to title IVC (Discretionary Projects and Programs) to permit funding of demonstration projects in the arts and humanities.

IV.2 Education Legislation

EXISTING PIECES OF EDUCATION LEGISLATION SHOULD EITHER BE FUNDED OR AMENDED SO THAT THE CULTURAL NEEDS OF OLDER AMERICANS CAN BE MORE FULLY MET.

Two possible actions are appropriate:

- Fully fund Title I of the Higher Education Act in order that older adults, especially those inadequately served by educational and cultural institutions may benefit from contact with the arts and the humanities.
- Include greater focus on arts and humanities services by and for older persons in the community schools program of the Elementary and Secondary Education Act.

IV.3 Enforcement of Age Discrimination Legislation

ALL GOVERNMENT AGENCIES AND PRIVATE INSTITUTIONS RECEIVING PUBLIC FUNDS AND INVOLVED IN THE ARTS AND HUMANITIES SHOULD ENFORCE BOTH THE LETTER AND THE SPIRIT OF THE AGE DISCRIMINATION ACT AND THE AGE DISCRIMINATION IN EMPLOYMENT ACT.

Among possible action steps are:

- Schools, libraries, colleges, museums and other cultural institutions should insure that sufficient and appropriate cultural programming is provided for older adults.
- These agencies should also engage older humanists and artists as employees or volunteers to an appropriate degree in their activities.

IV.4 New Emphases in Federal Programs

FEDERAL PROGRAMS STIMULATING RESEARCH OR GUIDING THE COLLECTION OF DATA IN REGARD TO EDUCATION AND CULTURAL MATTERS SHOULD INSURE THAT THE INTERESTS OF OLDER AMERICANS ARE FULLY MET.

Several possible courses of action are necessary:

- Encourage the Fund for the Improvement of Post Secondary Education to support more studies relevant to the needs of older learners, humanities scholars and artists.
- Urge the National Institute of Education to begin focusing attention on older people.
- Require the Office of Statistical Policy, Department of Commerce, to instruct federal departments and agencies, especially those relating to cultural affairs, to collect and record data by specific age categories beyond 45.
- Establish a senior staff position within the Secretary of Education's office to coordinate and promote programs relevant to the cultural and educational needs of older Americans and to the non-traditional providers of such.

V. RESEARCH CONCERNS AND NEEDS

The value of the arts and humanities to the lives of older people and their contributions to the cultural vitality of the nation are commonly appreciated but seldom understood and documented through research findings. Progressive generations of older Americans are better educated, benefit from broader exposure to and participation in cultural activities during their younger years, and consequently find the arts and humanities more a part of their lives. It is, therefore, imperative for today as well as tomorrow to study the full impact of older people's involvement in the arts and humanities. Furthermore, to facilitate exchange of information and promote development of the arts, the humanities and aging, research tools and dissemination mechanisms need to be developed or improved.

RECOMMENDATIONS

V.1 Research Priorities

INDIVIDUAL SCHOLARS AND RESEARCH INSTITUTIONS, ON THEIR OWN INITIATIVE OR WITH PUBLIC AND PRIVATE SUPPORT, SHOULD ACTIVELY PURSUE A DIVERSE RANGE OF THEORETICAL AND APPLIED RESEARCH PROJECTS EXPLORING ALL ASPECTS OF THE ARTS AND HUMANITIES AS RELATE TO AGING AND OLDER PEOPLE.

Some suggested courses of action are:

- Give high priority to projects which examine: correlates and variations in creativity over the lifespan, particularly in later life; implications of different cultural definitions of creativity with reference to later life; myths and stereotypes held concerning creativity in later life; the effects of involvement in the arts and humanities on the physical and mental health of older people.
- Urge the National Institute on Aging to expand its new interest in the creativity of older adults.
- Encourage a variety of research methodologies, including scientific techniques as well as approaches drawn from the arts and the humanities.

V.2 Resource Center for the Collection and Dissemination of Information

A NONPROFIT ORGANIZATION, UNIVERSITY OR THE GOVERNMENT SHOULD ESTABLISH A RESOURCE CENTER TO GATHER AND DISSEMINATE INFORMATION AND DATA ABOUT THE ARTS, HUMANITIES AND AGING.

The mission of this center can include activities such as:

- Develop comprehensive annotated bibliographies on the arts and humanities as relate to aging and older people.
- Compile a national directory of artists and humanities scholars involved with older adults and gerontology.
- Publish a periodical on the arts, humanities and aging disseminating research findings and programmatic activities.
- Convene or co-sponsor workshops, seminars and conferences on issues relating to the arts, the humanities, gerontology and older persons.

V.3 Use the Humanities in Public Policy Research

THE FORMULATION OF PUBLIC POLICY RELATING TO AGING ISSUES SHOULD TAKE ADVANTAGE OF THE MULTIPLE PERSPECTIVES OFFERED BY THE HUMANITIES.

To carry out this recommendation, the following actions, among others, are appropriate:

- o Call upon public officials and legislators to utilize scholars of history, ethics, philosophy and jurisprudence to help pose and clarify issues in health care, work and leisure, social security and private pensions, lifelong learning, and other matters relevant to aging.
- o Encourage humanities scholars to undertake, and funding sources to support, policy-oriented research concerning culture and aging.

VI. FUNDING SUPPORT

The arts and humanities, in common with other areas of contemporary America, confront economic difficulties related to inflation, energy costs, and diminishing resources. Although the arts and humanities often are ranked below "material" or "hard core" priorities, the predominate message of the Symposium was that cultural needs and activities must be equated in value and importance with other issues facing society and older Americans. Given competing demands on limited resources, innovative appproaches to funding clearly must be explored and utilized.

RECOMMENDATIONS

VI.1 New Patterns of Support Required

IN RECOGNITION OF THE INCREASING COMPETITION FOR STATIC OR EVEN DWINDLING RESOURCES FOR MANY ESSENTIAL SERVICES, INCLUDING THE ARTS AND THE HUMANITIES, THERE NEEDS TO BE SYSTEMATIC EXPLORATION AND DEVELOPMENT OF INNOVATIVE PATTERNS OF SUPPORT, INCLUDING VARIOUS MIXES OF PUBLIC AND PRIVATE MONIES AND OF CONTRIBUTIONS BY VOLUNTEERS.

To implement this recommendation, the following actions, among others, should be considered:

- o Urge organizations such as the Business Council for the Arts and the Independent Sector to study possible funding configurations and connections for the arts, the humanities and aging.
- o Encourage older people at the local level to become advocates for funding arts and humanities programs.
- o Develop special tax incentives to stimulate the private sector to support cultural activities involving elders.
- o Encourage the corporate sector to include self-enrichment opportunities through the arts and the humanities in programs and services available to company retirees and soon-to-be retired employees.

VI.2 Higher Priority for Funding Cultural Needs of Older Persons

GIVEN THE IMPORTANCE OF THE ARTS AND HUMANITIES TO OLDER PEOPLE AND THE POTENTIAL OF THEIR CONTRIBUTION TO THE ARTS AND HUMANITIES, PUBLIC AND PRIVATE FUNDING SOURCES SHOULD GIVE GREATER CONSIDERATION AND PRIORITY TO CULTURAL PROGRAMS AND ACTIVITIES INVOLVING OLDER PERSONS.

This suggests action such as the following:

- Individuals, voluntary and educational institutions, public agencies such as the Administration on Aging and the National Endowments for the Arts and the Humanities, or some broad coalition thereof, should conduct a campaign to convince private and public funding sources of the value and need for supporting various cultural acitivites for and by elders.

- Continue and expand subsidies for both admission fees and transportation costs to enable older people to attend performances and exhibitions. Models for further dissemination are the voucher system and a "patron system" whereby purchasers of season tickets can also buy a seat for an older person at a reduced rate.

- Support professionals in the arts and the humanities to provide assistance, when required or requested, to programs in environments such as senior centers, schools, nursing homes, libraries and other locations in communities.

- Existing public programs such as artists in schools should provide for older persons by establishing artist/humanist residencies in senior centers, nursing homes and other similar facilities serving older people.

VI.3 Various Funding Needs

PRIVATE AND PUBLIC FUNDING SOURCES SHOULD SUPPORT A FULL RANGE OF PROJECTS AND ACTIVITIES IN THE STILL EMERGING FIELD OF THE ARTS, THE HUMANITIES AND AGING IN ORDER TO PROMOTE AND TRY NEW APPROACHES AND TO STIMULATE THE FIELD TO REACH ITS FULLEST POTENTIAL.

In addition to support for the many ideas and activities proposed elsewhere in this report, several needs merit special mention:

- Demonstration and model projects which have the maximum potential for replication in many localities and which can be made self-sustaining or conducted with high cost efficiency.

- Arts and humanities programs addressing the needs and interests of the most culturally vulnerable ethnic minority elders.

- Expanded outlets for older people to market their crafts.

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the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on
Saving for Retirement

MCR-14

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

SAVINGS

American Council of Life Insurance
1850 K Street, N.W.
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The Graduate School of Business
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New York, New York

Alexandria, Virginia
January 16-17, 1981

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Saving For Retirement

INTRODUCTION

In today's inflationary economy it is more difficult than ever for most Americans to put aside money for retirement. Yet it is vitally important that more saving take place if our nation is to continue to grow and remain competitive in world markets. Expanded saving can provide needed financial security for millions of older Americans and contribute to an expansion of the productive capacity of this nation. With the proportion of the elderly population growing, an increase in capital formation is essential to protect the retirement of all Americans.

The Graduate School of Business, Columbia University and the American Council of Life Insurance recently convened a Mini-Conference on Saving for Retirement to support the White House Conference on Aging by stimulating thinking about how saving for retirement can be increased. Held on January 16-17, 1981, in Alexandria, Virginia, knowledgeable people from academia, government, business and organizations concerned about the elderly discussed the twin issues of saving and retirement. The discussions, moderated by Professor Robert Shay of the Columbia Business School, followed presentations by leading scholars and businessmen who have long studies this area. (Conference participants are listed at the end of this report.

The discussions were lively and stimulating. A variety of points of view were discussed. To communicate to you the central themes and ideas produced, the sponsors asked Dr. Phillip Cagan, widely-known economist from Columbia University and director of the conference, to prepare a report of the meeting. No votes were taken at the meeting, nor was consensus sought on any subject, therefore the following report may not reflect the views of every participant. Nor does it catalogue every opinion brought forth. The report is intended to convey ideas about increasing saving, background information about the financial status of the elderly and how increased saving could improve their resources. The papers prepared for the Mini-Conference will be published in full later in the year.

We believe that the White House Conference on Aging can and will make a major contribution to the status of the elderly, and indeed, to all Americans. We hope that the information in this report will aid you in thinking through the issues of how to increase saving.

We want to take this opportunity to thank you for your participation in the White House Conference on Aging, and to express our appreciation to Professors Shay and Cagan, and the others who participated in our Mini-Conference for their contributions to the effort to improve the financial situation of older Americans.

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HIGHLIGHTS OF A MINI-CONFERENCE ON SAVING FOR RETIREMENT

Prepared by Dr. Phillip Cagan, Professor of Economics, Columbia University

OVERVIEW

The financial condition of older Americans has improved substantially since the first White House Conference on Aging in 1961, despite the recent high levels of inflation. Today only 15 percent of the elderly have cash incomes below the poverty level compared with 35 percent in 1959, and, if the money value of in-kind benefits is appropriately counted, just six percent are now below the poverty level.

Although not actually in poverty, however, many of the elderly are only moderately above that level. Many have low incomes in relation to their standard of living before retirement.

Social Security plus Supplemental Security Income (SSI) is the main support for many of the elderly. These provide only a basic minimum. It will be difficult to increase Social Security benefit levels in the present political environment, and in any event the system already faces severe financial strains. Indeed, some people propose that a lightening of the burden on the working population that pays the costs of the system needs to be given serious consideration.

Greater employment after age 65 could improve the incomes of the elderly, and some of the incentives for early retirement should be removed. But a sizable increase in gainful employment by the elderly with low incomes appears unlikely because a large proportion of them are disabled and unable to work.

The most promising way to improve the incomes and financial security of future retirees is through more individual saving during their working years. Other industrial countries have much higher saving rates than the U.S., suggesting that our rate can be increased. Saving during working years can add substantially to consumption levels during retirement. Increased saving can also help meet -- as nothing else can -- the pressing demands to provide more capital for American industry.

The conference discussed the prospects for increasing individual saving and the most promising ways to encourage it:

1. Saving tends to be habitual. Those who begin to save early in life continue to save thereafter. While the majority of Americans say they want to save, very few say they are satisfied with the amount of money they do save. Lack of knowledge of how to make financial plans for retirement and to make sound long-term investments contributes to low saving rates.

   Education about pre-retirement planning and financial investments would supply a widely needed service. Employers could encourage employees at all ages to save by taking the initiative to provide practical financial counseling services. Employees usually tend to trust services proved by their employer rather than by outsiders. Employers can now provide financial planning tailored to each individual's specific needs and circumstances quite inexpensively.

2. The provision of convenient and attractive methods for employee saving has been shown to increase saving. The traditional methods that have been successfull are payroll deduction plans and supplemental insurance benefits. Other types of company thrift plans which are voluntary and supplement company pension plans required of all employees have been developed. Most of these company thrift plans offer full or partial matching contributions by employers, while additional discretionary contributions by employees are usually permitted. Such plans have been very appealing to employees at all salary levels. The convenience and built-in discipline of the payroll deduction are important features that stimulate saving.

   These thrift plans have brought substantial benefits to employers as well. They build morale, enhance employee-employer relations, and provide participants with an important supplement to pension plans.

3. A change in the law to allow tax deductions for employee contributions to qualified company pensions, thrift plans and IRAs could encourage more saving for retirement. The tax deduction might also encourage small businesses to set up pension plans based primarily on employee contributions. As the businesses grow, the employers could assume more of the costs of the plans. Hence the retirement saving tax deduction could help expand the coverage of pension and thrift plans.

4. Tax credits for saving by low-income workers, who are usually the least prepared for retirement, would enable them to begin to save.

Saving has to be increased to finance the retirement needs of our growing elderly population and the future capital requirements of the economy. To accomplish this, the effects of government policies on saving must be taken into account. An expansion of private company pension and thrift plans would contribute to saving, while an expansion of Social Security would not. Taxes on saving and on the returns from investment discourage saving and capital investment. Federal budget deficits absorb national saving and leave less to finance capital investment.

An end to inflation would do more to improve the financial condition of the elderly and the nation than any other act of government. Inflation exacerbates the penalty that our tax system imposes on saving and investment. Inflation also eats away the real value of financial assets and discourages traditional forms of saving that finance capital investment.

New tax incentives are important for the success of thrift plans and saving in general. At the same time tax reductions must be selected with care to give the most increase in saving per dollar of tax revenue lost and to benefit low-income savers as much as possible.

After retirement those with low incomes may, if they own a home, be able to use home equity conversion as a special way to increase their incomes. This is a method by which elderly homeowners can sell their homes, acquire an annuity, but continue to live in the house for the remainder of their lives or for as long as they wish. When they die or vacate the house, the buyer takes possession. This is a promising financial arrangement and could be especially attractive to single people of advanced age who need more income. Serious obstacles continue to prevent the widespread use of this arrangement, however, and further study and experimentation is needed.

Highlights of the Meeting

(I) A Profile of the Financial Condition of the Elderly

Despite the many problems still faced by the elderly, there has been a gratifying improvement in their economic condition. Money incomes of the elderly have risen dramatically in real terms over the past decade, mainly from Social Security and other maintenance payments and private pensions. Only a small minority still live in real poverty. This hardly means that all is rosy for everyone above the poverty line, but it does indicate substantial progress toward the goal of providing all of the elderly with the means to enjoy a comfortable life.

Public policy for the elderly has focused on the problem of poverty. Government statisticians have determined the poverty level from the cost of a basic nutritional diet and survey evidence that most low income households spend three times as much for all necessities as for food. Adjustments are made for the size of households, age of children, and sex of head, (but not region, except for farm versus nonfarm), and the level is updated every year for increases in the cost of living. In 1979, for example, the nonfarm poverty level for a single person 65 and over was $3,479, and for two people where the head of the household is a man 65 or over it was $4,394. This is applied to everyone in each subgroup, whereas people under different circumstances may need more or less. The dollar figure for the poverty level is only a rough indication for making comparisons, but it is useful since the number of people above or below this level is the only general measure of minimal living standards.

Using the poverty levels in each year as benchmarks, the Bureau of the Census counts the number of people in each sub-group who fall below them. For 1979, the latest year presently available, there were 3.6 million elderly persons (that is, 65 and over) in households with money incomes below the poverty level. Money income includes a single person's or household's total income from work and investments, pensions, Social Security, Supplemental Security Income, and other cash maintenance programs (public assistance, veterans compensation, railroad retirement, etc., though not food stamps or Medicare). The 3.6 million figure for 1979 is a large number, but it represents a substantial decline from 4.7 million in 1970, at the beginning of the decade, and from 5.5 million in 1959, two decades earlier. As a percentage of the growing number of elderly in the population, the decline is dramatic. In 1959 the percentage of the elderly in poverty was 35 percent, in 1970 it was 25 percent, while in 1979 the 3.6 million figure represented 15 percent.

In less than two decades, therefore, the problem of income poverty among the elderly has been reduced appreciably. Most of this reduction reflects the increase in Social Security benefits. Maximum benefits for a couple were about a quarter in excess of the nonfarm poverty level in 1965, but over double this level in 1979. In the past two decades Social Security benefits in total have increased twice as fast as national disposable income, rising from 2½ percent of disposable income in 1960 to almost five percent in 1980. All other Federal income maintenance programs in total have had a comparable growth.

The importance of Federal transfer programs for the elderly can be seen in another way. If we count only money income from work, private pensions, and all other nongovernmental sources, data available for 1976 show 9.6 million elderly persons -- 6 out of 10 -- in poverty. When we also count cash transfer payments from the government, that is, Social Security and other retirement and maintenance programs, the poverty group declines by almost three-fourths to 17 percent for 1976. Social Security is the mainstay of retirement income for the vast majority of the elderly and will continue to be.

Also, we should not overlook the important contributions to the economic welfare of the elderly of benefits received in kind and paid for by government programs. The most important of these is Medicare, and the second most important for many with low incomes is food stamps. If we add the money value of these and other such progams to the other money income of the elderly, the number in 1976 still below the poverty level was only 6 percent. Allowance for income taxes paid does not affect this count, since people with low incomes pay little or no income taxes.

Medicare payments were $25 billion in 1978, which averaged over $1,000 per person 65 and over. Of course, actual benefits went disproportionately to those who received extensive medical services. There is some question whether the elderly would have spent all of this $25 billion on medical services, if it had been distributed in cash before hand to the elderly for whom it was used. They might have had other more pressing needs. Many of those below the poverty level except for Medicare benefits, therefore, may still have had a poverty standard of living in all other respects. Nevertheless, for most of the elderly, medical services are among their most important expenses, and they would under any circumstances choose to spend a large fraction of their incomes on such services, and thus necessarily spend less on other things that were important in their budgets when younger. It is not misleading, therefore, to count Medicare payments as part of the income of the elderly, though in some cases the inclusion may overstate their economic well being.

Who are the elderly still below the poverty level? These are people who do not qualify for substantial Social Security benefits and do not have private pension plans or other major sources of income. Two-thirds of them are single people, predominantly women. While women represent only 59 percent of the elderly population, they are twice as likely as men to have poverty incomes. The incidence of poverty is also particularly serious among certain ethnic groups. One is elderly blacks, of whom 36 percent were below the poverty level in 1979, though this was a decline from 48 percent as recently as 1970 (40 percent in 1972).

The incidence of poverty, though diminishing in importance over time, remains a knotty problem in certain groups that are hard to reach by standard programs. Supplemental Security Income has been a major help, but it does not eliminate the problem of poverty. While elderly blacks have less incidence of poverty every year, the decline has been slow. The solution sometimes proposed of providing jobs for the elderly poor will not reduce poverty appreciably. It is true that the elderly who work are far less likely to be in poverty; in 1977 only 5 percent of the elderly who worked had money incomes below the poverty level compared with 16 percent for those not working. But only 18 percent of the elderly worked in that year. There are various reasons why most of them do not work for money, probably the most important being a preference not to. For many, however, particularly those with low incomes, disabilities that prevent work are important. According to survey estimates of people 55 and over, the fifth with the lowest incomes commonly reported disabilities that prevented or limited work (53 percent reported such disabilities), and only 8 percent of this income group did work. In contrast, the four-fifths with the highest incomes reported few disabilities that prevented or limited work (8 percent reported them), and 56 percent of this income group did work. Disabilities are a particularly severe problem among blacks. For blacks 55 and over, the fifth with the lowest incomes had a high incidence of disabilities (two-thirds reported them) and only 11 percent of this income group worked, whereas the four-fifths of blacks with the highest incomes had only 18 percent who reported disabilities and 64 percent of this income group worked.

Disability is clearly a major problem for the elderly, since it increases the need for high-cost services at the same time that it reduces the possibility of earning additional income by working. As part of the problem of poverty, those with disabilities require special attention.

Although the number of elderly people in poverty has diminished substantially over the past decade and as of 1976, as said, only 6 percent of them had total incomes and in-kind governmental benefits below the poverty level, many are only moderately above the poverty level. Another 10 percent or so have incomes that are only 25 percent above that level. Those who might be considered well off financially are a minority. That a large number of the elderly are bunched just above the poverty line is not surprising, however. Although full-time work can provide adequate income, only about 18 percent of the elderly work, as noted, and most of the work is part time. Almost 90 percent of the elderly receive Federal transfer payments in various forms, and for most of them this is the major source of income. These payments are not intended to provide more than a basic minimum. The nonworking elderly who enjoy higher incomes supplement Social Security with either a private pension or accumulated savings that provide rental, interest, and dividend income. While private pension plans are maturing and will become increasingly important in the future, they are not yet a major source of income for the majority of retirees. About one-fifth of the population over age 65 receive income from private pension plans.

In one important respect the data on income and in-kind benefits understate the welfare of the elderly, because over three-fourths live in their own home on which they have partially or fully paid off the mortgage. Their "true" incomes should be reported as higher to take account of the equivalent rental value of the nonmortgaged (equity) part of their homes. This can make a big difference, particularly for low income groups. Although the elderly homeowners with large equity are mainly in the higher income groups, the tenth of the elderly with the lowest incomes have at least some equity in their homes (about 60 percent do), for which the rental value adds to their true incomes.

What all these data indicate is that poverty is no longer a problem for the elderly that calls for substantial additional public funds. Much can now be accomplished by devising programs that are cost effective in dealing with remaining inadequacies and that can help the working population to prepare for retirement more effectively.

(II) Improving the Living Standards of the Elderly

Within the present income of the elderly their welfare can be increased further by improving the services that they already pay for and by providing needed services that they are able to pay for but cannot obtain. In general, however, increases in their welfare will require purchases of additional services and therefore an increase in their incomes, either directly in money terms or indirectly through in-kind benefits. Their incomes can be increased by government transfer programs financed by taxes (principally Social Security benefits) or by individual saving for retirement. A special kind of increase could be provided by transforming the accumulated equity in property of the elderly into income supplements (called "reverse annuity mortgages"). Each of these sources of income was discussed at the conference.

(II.a) Social Security Benefits

These payments provide a basic floor of protection. Primary benefits are based on the amount of the individual's covered wages. Additional benefits are provided for dependents. Benefits after retirement are now indexed to the Consumer Price Index, which is intended to maintain their purchasing power against the persistent inflation of dollar living costs. In addition, in computing initial benefits, wages in covered employments are indexed for changes in wage levels over the person's working years.

Benefits are designed to replace only a fraction of working life income; under present schedules, benefits will eventually be about 40 percent of average pre-retirement incomes for single persons and 60-64 percent for couples. This will provide a standard of living moderately above the poverty level for retirees without any other source of income.

A good argument can be made that benefit levels under Social Security should not be increased further in real terms. Since the system is financed on a pay-as-you-go basis by the Social Security taxes paid by workers and employers, it is argued that workers should not be expected to provide through taxes higher benefits than are necessary to meet the basic needs of retirees. Enjoyment of a standard of living higher than this is viewed as the responsibility of each individual and his family, or the employers, not of society at large. Such a view does not preclude further efforts to aid the 6 percent of the elderly still below the poverty level by increasing Supplemental Security Income and other maintenance programs, but it does argue against any further legislated across-the-board increases in the present schedule of Social Security benefits.

Whatever Congress and the nation believe a desirable level of Social Security benefits should eventually be, it is unlikely that increases in real benefits, other than perhaps in Supplemental Security Income, can be seriously considered in the decades ahead. The financial costs of the system have become larger than was ever expected, and they are going to become even more burdensome on the working population in the future. The reason is that the changing age distribution of the population is raising the number of beneficiaries in relation to the number of workers who pay the cost. The ratio of people 65 and over to the labor force at present is 24 percent. In 40 years, when today's young workers are retiring, the ratio will be 33 percent, and 10 years after that it will be 40 percent. Taxes to finance the system have recently risen sharply and will have to rise even further in the years ahead. The total OASDI tax rate in 1981 was 13.3 percent and was scheduled to rise to 15.3 percent by 1990, but this is still insufficient to finance the system over the coming decades and will in fact have to be much higher, though no one knows how much for sure.

Given the tight financial constraints on the Social Security system, therefore, the most promising way to increase the income of retirees is through individual saving.

(II.b) Increasing Individual Saving

People save by refraining from using all of their income for current consumption and acquiring financial assets or property with the remainder. The accumulated purchasing power can be used for later consumption, particularly during retirement. The most common forms of individiual saving to prepare for retirement are (1) contributions to company pension plans by employees and employers, and (2) the accumulation of equity in homes through a down-payment and gradual amortization of the mortgage. Saving by individuals on their own in savings deposits, bonds, stocks, and other financial assets have been encouraged by the relatively new Keogh and IRA tax-deferred savings plans. It is a fact, however, that the vast majority of people do not save much on their own. If they do not acquire a home or have a pension plan with their employer, they save practically nothing, and most of them reach retirement with virtually no assets except the promise of their Social Security benefits. So far the tax-sheltered plans are mainly used by the higher income groups who do most of the saving.

Yet surveys consistently report that people who save little or nothing for retirement say they would like to save more. If somehow they could, they would certainly be better off financially in later years. There appears to be two major reasons why most people do not save more for retirement despite a desire to do so. One is psychological: saving requires discipline and restraint. Unless the savings are tied up in a pension plan, it is hard for most people to refrain from spending the funds on one thing or another. The other reason is that placement of savings in sensible investment outlets requires financial knowledge and expertise, which most people do not have.

An important negative influence on saving in this country is our tax system, which effectively penalizes most forms of saving. We tax all earned income, including the part saved, and then tax the income earned on the invested savings. The tax system also imposes a double penalty on investment in common stocks: a tax is levied on corporate income and then on dividends paid to shareholders above a small deductible amount and on any capital gains on the stock when sold.

An exception to the tax penalty on saving is made for tax-deferred retirement plans. Tax provisions have encouraged the growth of company pension plans, but were not available for individuals on their own until recently when the Keogh and IRA plans were introduced; being relatively new, however, the latter are not yet widely used. An old and widely used tax deferment vehicle is owner-occupied homes, where the rental value is not taxed as imputed income (which some foreign countries do tax) and mortgage interest payments are tax deductible. The important consequence is the strong encouragement of homeownership in this country and the disproportionately large amount of saving via equity in homes. The income on this equity (received in kind as housing without rent) is consumed during retirement but not the equity itself, as is discussed further below.

Inflation has severely aggravated the tax penalties on saving. Interest rates tend to be higher on the average with inflation to compensate for the loss of purchasing power of invested funds, but, since all the interest income is taxable, taxes are paid on the part compensating for loss of purchasing power. On the other hand, interest on borrowing is deductible for taxes, which encourages consumption financed by debt. Inflation also raises the dollar value of property and thus gives rise to capital gains in dollar but not necessarily in real terms that are taxed when the property is sold, which is again taxation of the principal. This reflects the lack of indexing in the tax system, which also has the effect under inflation of pushing people into higher tax brackets. Also because of lack of indexing in historical cost depreciation accounting, inflation has increased taxes and reduced the after-tax rate of return on business investment, though this has been partly offset by tax provisions for accelerated depreciation and investment credits.

Despite the obstacles and disincentives to individual saving, there are indications that, given help and encouragement, people will save more. Compared with the U.S., other industrial countries provide more tax incentives for saving and have much higher saving rates, though lower taxes may not be the only reason for the higher saving rates. Our close neighbor Canada increased its tax incentives for saving in 1974, and it has had a much higher saving rate since the mid-1970s. Economists are still investigating the degree to which the incentives caused the increased saving, but the apparent correspondence is highly suggestive.

Company pension plans in the U.S., in which employers' contributions are tax deductible, have grown rapidly. In 1979 it is estimated that about half of all workers were covered by private pension plans. The plans have been a significant source of financing for business investment. Major pension and retirement programs accumulated $41 billion in 1979, which represented a substantial part of the total funds used for private investment in the economy.

Another indication that saving is responsive to incentives is provided by the experience of some U.S. corporations who have inaugurated voluntary employee thrift plans to supplement employee participation in company pension plans. A few thrift plans provide personal financial counseling, particularly on how to prepare for retirement, and are set up with mild but effective penalties to discourage backsliding. Employers match some fraction of employees' contributions. Although this by itself increases the employers' immediate costs, it may not make his total pension costs higher and, in any case, appears justified by enhanced employee appreciation and loyalty.

While thrift plans and pension plans provide the expert management of invested funds that many people find helpful, a drawback at present is that the individuals own contributions do not qualify for tax deductibility. Changes in the law are needed to make voluntary employee contributions to a company pension plan or IRA tax deductible. While it is not known to what extent such plans, if tax deductible, would enlist many employees who presently do not save much for retirement, the plans do appear promising. The limited evidence suggests that participation could be high and fairly steady.

(II.c) Reverse Annuity Mortgages

Saving during a person's working years can be fully converted into income during retirement by selling off the accumulated assets. This cannot be easily done, however, for one important asset -- the equity of owner-occupied homes. If retirees want to remain in their homes, they cannot sell; consequently, they benefit from having paid off part or all of the mortgage, but the equity value is not used and passes to their estates. This is not a minor item. Most of the elderly, as noted, have accumulated equity in homes, some a fair amount, and most of the assets they own are in this form. Moreover, inflation in the past decade has greatly increased the value of this equity by raising house prices more than the overall cost of living. Many elderly find themselves house-rich and income-poor: they are rich in terms of the market value of their owned homes but have incomes that barely allow them to pay for upkeep and property taxes.

A new financial arrangement has been proposed to solve the problem of unused homeowner equity. The basic idea is to convert the equity value of homes into supplemental income during the owner's retirement years. While details of the arrangements can take various forms, most provide for sale of the house with a convenant that the seller has the right to occupy the house without rent for life or as long as desired. The purchaser obtains possession of the house when the seller and spouse die (or voluntarily vacate earlier for extra payment), for which the purchaser provides a sum of money which the seller takes as a lump sum or an annuity. In some forms of the agreement the purchaser may also agree to pay for all maintenance expenses.

Of course, the equity in the house no longer enters the seller's estate as a bequest to heirs, but many retirees may not veiw leaving the house as a bequest to be important or desirable, even though this usually occurs for want of alternative arrangements.

Reverse annuity mortgages will generally not be feasible for homeowning couples with a long life expectancy ahead of them. For then the expected delay in possession of the house makes the expected return to the purchaser too low in relation to the cost of the funds provided to the seller. With an aged single person, however, the arrangement becomes attractive to both parties. Here the shorter life expectancy makes the expected return higher and the annuity costs lower. Moreover, it is precisely this group of elderly homeowners that can usually use the added income from equity conversion the most.

Although reverse annuity mortgages would meet a particular need, they face serious practical difficulties and must be developed further before they can become widely used.

(III) Providing an Expanding Economic Base To Support a Growing Elderly Population

Financial provisions for retirement can take various forms, but all of them represent claims by the elderly on economic resources. Except for the small number of elderly who continue working, these claims come out of the total output of the economy which at any given time is produced by the existing labor force and the accumulation of capital from the past. In coming decades the economic needs of the growing elderly population will have to be provided by a commensurate expansion of the economic base or they will diminish what will be available for the rest of the population. A greater expansion of the economic base is indeed essential for the general well being of the nation. In view of the slower growth of the labor force, continued expansion of the economic base requires that more of the elderly work and that capital accumulation be relatively higher.

Many elderly people want to continue working beyond the traditional retirement age, and obstacles to their doing so are breaking down. It used to be thought that elderly workers took jobs away from young workers, but that notion born in the 1930s Depression is no longer appropriate today. With declining population growth, we need and should encourage the elderly to stay on the job to be productive members of the labor force and to give us the benefit of their training and experience. To encourage gainful employment the earnings limitation of Social Security has been relaxed, and there are proposals to relax it further. The mandatory retirement age of 65 has been largely eliminated. Job discrimination on the basis of age has been banned. In these various ways our society is inviting and making it possible for the elderly to continue working as long as they can and want to.

At the same time many of the elderly find it impossible to work because of poor health or disabilities, or may prefer not to work in order to pursue various activities and endeavors which are not classified as gainful employment but which nevertheless are useful to themselves and often to society as well.

Not only do few of the elderly now work beyond 65, but there has been a growing tendency toward early retirement. This tendency, once confined to men, is now showing up among working women. In part if may reflect economic incentives to retire, since many pension plans do not reduce benefits very much to penalize workers who retire early. The low penalty is a carryover from the old view, now no longer in favor, that stressed the need for upward mobility of younger workers through early retirement of older workers.

It also seems to be widely believed that the benefit schedule of the Social Security system encourages early retirement. In fact, however, the system provides substantial additional income benefits for those who continue working from 62, when early retirement is allowed, to 65, when retirement is "normal". These additional benefits should be widely publicized so that workers make their retirement decisions with a full understanding of what they forfeit by retiring early.

Although the tendency toward early retirement may in part reflect a misunderstanding of Social Security benefits, for the most part it probably reflects, as said, a preference by most workers for early retirement, inasmuch as they enjoy the financial ability to retire early and live comfortably. Although making it possible and acceptable to work after 65 should encourage more people to do so, particularly if the health of the elderly continues to improve, the present situation does not suggest that the percentage of the elderly who work will ever be large, and the trend toward early retirement may well continue.

Delayed retirement is not likely, therefore, to offset our demographic trend toward a higher ratio of retirees to the labor force. The needed expansion of the economic base will therefore require greater capital formation. Basically this means we have to consume less of our output and devote more of it to investment. While providing for retirement through saving accomplishes capital formation, however, not all provisions for retirement have this result. Capital gains increase the value of assets, which can be cashed in during retirement to purchase goods and services, but they add nothing to capital resources. This has been true of two important sources of financial support for the elderly -- real capital gains on owned homes and the promised benefits of Social Security.

Capital gains on houses in real terms -- that is, price increases over and above the general cost of living -- have reflected the inflationary environment. Inflation has not in general been a benefit to all the elderly, to be sure, because real capital gains on houses have been largely offset by real capital losses on financial assets. But most of the low-income elderly homeowners have few other assets and so have had net capital gains. They should, of course, take full advantage of the capital gains on their homes if they can, by reverse annuity mortgages or other means. House prices are now extremely high relative to the general price level, and the capital gains are unlikely to be as large in the next decade as in the last.

Although capital gains provide purchasing power, they create a potential claim on the output of a given economic base without increasing it. They should be distinguished from the usual accumulation of homeowner equity in which income is saved rather than spent on nondurable consumer goods. Here homeowners pay for the production of new capital in the form of houses. If the equity is liquified by a reverse annuity mortgage and consumed during retirement years, this dissaving in later years is offset by the saving in earlier years, so that the economic base is not thereby reduced over the person's lifetime.

Social Security is a financial arrangement in which present workers support present retirees in exchange for the subsequent support of future workers. A capital fund is not accumulated, as was done temporarily in the beginning years of the system. If contributions had all along been put into a capital fund eventually to finance the benefits, the fund would have grown as long as the labor force did and have provided financing for capital formation. Because no capital fund exists, however, there is concern that the system may have actually reduced the nation's capital accumulation, if workers have taken the existence of Social Security benefits as reason to save less. The overall effect on national saving is not clear, however.

For workers who would never save on their own, Social Security could not reduce their saving. For others who are inclined to save for retirement, Social Security could lead them to reduce their other saving. But it is also possible that they would continue to save as much as before in order to retire early or to provide better for their children, as the previous generation may have also done for them, now that Social Security benefits paid for by taxes on the younger generation have lightened the burden of saving for retirement. This is an empirical question as to how people in fact use and adjust their saving, and the evidence is not clearcut. While few would argue (as it once was) that Social Security increases national saving, the experts are divided on whether Social Security has made the nation's capital stock smaller than it would otherwise be -- to a major extent or hardly at all.

If the Social Security system has reduced saving, that would mean we should consider national policies to make up for the shortfall, but certainly not that the system is undesirable or that the pay-as-you-go feature should be changed. On the contrary, Social Security has allowed millions to retire in dignity. Despite the remaining pockets of poverty, the system is widely applauded for its accomplishments, and, as opinion polls continue to show, it is universally accepted by the public. It will remain our bottom line of support for the elderly.

The nonsaving character of the Social Security system makes it desirable that further improvement in the financial condition of the elderly be obtained through increases in saving that add to the nation's capital resources. In that way the increasing burden on the working population owing to demographic trends can to some extent be alleviated. In addition to a growing proportion of retirees, the nation also faces large investment demands for the future needs of capital-intensive industries. The recent slow growth in productivity in the U.S. economy is attributed by some to inadequate capital replacement and expansion. These developments point to a need for greater capital investment to maintain our economic strength and industrial leadership.

The nation's capital needs are outstripping the supply of saving which provides the financing. U.S. national saving has been low compared with other industrial countries at least since World War II, though it has remained more or less on the same level until recently. Since the mid-1970s, personal saving has declined by a third. The decline appears to be more than a short run cyclical fluctuation and not an artificial result of the recent overstatement of reported money incomes because of the large inflation premium in interest payments. The decline in saving could be due to a variety of factors, such as an upward pressure on household expenditures until people adjust to the higher costs of energy, the bulge in the population at the ages when purchases of houses and furniture are heavy (since much of the decline in saving reflects the negative effect of increases in consumer debt), and diversions from normal saving channels owing to high inflation. Since the causes of the decline in saving since the mid-1970s are not clear, we do not know whether it is temporary or will persist. Many people believe that we need to encourage more saving now, because the nation can use all the saving that can be generated. It would be all to the good if the recent decline should reverse itself, but we cannot count on such a reversal.

The twin goals of generating the financing for greater capital formation and of improving the financial condition of the elderly can be met by encouraging more saving for retirement. Although capital financed by saving for retirement is eventually used up through dissaving, the growing population will provide more capital over time than is dissaved during retirement. The example of other countries, though not entirely applicable, suggests that the U.S. can achieve higher rates of saving and capital formation.

(IV) Increasing National Saving

National saving can be increased by encouraging individuals to save more. The private sector can contribute to this result, as noted above, by providing convenient employer pension and thrift plans and the information that people need for sensible financial planning and investment. Whether such private sector initiatives could have much effect on saving is not known, but the importance of the objective justifes a strong effort. The most significant contribution, however, can undoubtedly be made by government policy in removing the disadvantages to saving from inflation and taxation.

(IV.a) The Need to End Inflation

The traditional forms of saving have been devastated by high inflation rates. The elderly are more aware of this than anyone else, and consistently identify inflation as their number one problem. Inflation eats away the purchasing power of saving put into assets with a fixed-dollar value, such as savings deposits, bonds, and annuities, which have traditionally been the assets accumulated by the elderly. When the inflation rate escalates, interest rates tend to rise as compensation on newly issued securities, but not on funds tied up in existing securities until they mature. On top of the real losses due to inflation, the tax system, as noted earlier, compounds the losses by taxing the higher interest. The alternative of investing in assets that vary in price and might be able to keep up with inflation, such as real property and common stocks, is risky. These assets, except for homeownership, are not investments that most people can easily manage. Moreover, the rise in their dollar values is taxed as capital gains.

Inflation also creates an environment of uncertainty that increases the risk of all but the shortest-term securities. Common stocks have declined in real market value since the late 1960s and failed to provide a hedge against inflation, as traditionally it was thought they would. Perhaps stocks will provide such a hedge in the future, but no one knows for sure, and individuals are stymied in using this means of protecting their savings against inflation. Houses have been the only real hedge for most people, and prices of houses have skyrocketed as a result, making their long-term real value at present prices also risky. Should inflation be reduced, the premium in house prices will tend to come down. The only sure way to be protected against inflation is by a payment that is indexed, which is now done for Social Security and other Federal retirement programs, and in effect partially for some private pension plans where payments are based on wages in the final years before retirement. Most benefits paid by private pensions after retirement are not indexed, however, except for occasional adjustments. Indeed, indexing of private pensions would be difficult to do because of the lack of assets to accumulate in the pension fund that would keep up with inflation to provide the financing.

The result has been that many people are either discouraged from saving or are led to put savings into assets that, though more risky and less manageable, have a change of keeping up with inflation. This has raised the demand for and prices of houses and other real estate, as well as gold, art, and antiques. The rise in demand for these valuables does little to increase the economic base, except for houses and real estate, and even for these, inflation has so far produced mainly capital gains on existing property and little additional supply.

While some of the adverse effects of inflation on capital formation should be corrected by changes in specific taxes, there is no substitute for ending inflation. No better impetus to national saving and to a solution for the financial problems of the elderly could be found, and it merits the nation's strongest effort.

(IV.b) Tax Incentives To Increase Saving

A reduction in the tax on income used to acquire particular financial assets and on the income they yield will increase the rate of return on saving. For example, recent proposals are that contributions to company thrift plans be made tax deductible, the deductible limits on Keogh and IRA plans be raised, and interest and other investment income be made tax-exempt up to certain amounts. Such specific tax reductions would undoubtedly induce people to save more in those forms. Whether they would increase total national saving, however, depends on the magnitude of several accompanying effects.

First, a higher rate of return means that the same amount of dollars saved provides more retirement income. Many people may be satisfied with a certain level of retirement income and may not want to consume less during their working years in exchange for more during retirement. These people would not save more in total and might save less. Others, however, may find that a higher return justifies greater saving when they can get more retirement income for each dollar of present consumption given up.

The evidence on how people respond to changes in the rate of return on saving is mixed, and the net effects on national saving are not known. However, for those who have done little or no saving, any induced increase due to tax incentives would represent a net increase. It therefore appears likely that, unless the additional saving of the previously low savers was small and was offset by some reduction in the saving of high savers, the net effect would be to increase national saving.

Second, we must consider what happens to government dissaving as a result of decreased revenues from tax reductions on certain forms of saving. People will take advantage of any reduced taxes by channeling their saving into the favored forms, whether they save more in total or not. As one result, tax revenues will certainly decline in the short run. In addition, the government must either reduce expenditures, raise other taxes, or finance a larger deficit. If the government raises taxes on other forms of saving or dissaves more itself to cover a larger deficit by borrowing funds that would otherwise finance capital investments in the private sector, it thereby contributes to a reduction in national saving that may offset whatever increase individuals contribute in response to the tax reductions. A policy of increasing the nation's capital resources is therefore not achieved by tax incentives to increase some forms of individual saving if it is combined with budget adjustments that decrease other forms of national saving. In general, the appropriate budget adjustments to tax incentives for saving are reductions in noncapital government expenditures or an increase in taxes on private consumption expenditures.

Third, since the government must make up the tax revenues lost when it reduces taxes on saving, it is desirable to obtain as much increase in saving as possible per dollar of tax revenues lost. This raises a third consideration in using tax incentives to increase saving. Tax incentives, as noted, induce people to substitute among forms of saving and do not necessarily increase their total saving dollar for dollar. It is estimated that every dollar of saving in company pension plans, for example, leads individuals to reduce their other saving by 65 cents for a net increase of 35 cents. Similarly, a limited income tax deduction for interest earned would reduce the taxes of people who have such earnings but would give no additional incentive to save to people who already have interest earnings above the deductible amount. Morever, people with interest earnings below the deductible amount tend to be low savers and probably would be the least responsive to the incentive to save more. If employee contributions to company thrift plans and IRAs were given a tax inducement, on the other hand, the amount of saving generated per dollar of tax revenue lost would likely be high, because the potential participants appear to do little other saving which the tax-deferred saving could substitute for.

As these considerations indicate, tax incentives vary in their effectiveness, and a careful choice should be made among the various possibilities after examining their likely effects. Other considerations should also be weighed in the choice, because of possible conflicts among deserving purposes. For example, it is desirable to give the strongest tax incentives for saving to those who now save the least, but at the same time we want to obtain the most increase in national saving per dollar of tax revenues lost, which is most likely to be accomplished by tax incentives for people who are inclined to do a lot of saving. There are no simple answers. While compromises will be necessary, they should not be allowed to delay decisions. The capital needs of the nation are pressing.

(V) Investing National Saving in the Most Needed Capital Resources

The nation's saving is allocated to borrowers in financial markets, generally to the highest bidders, except that government taxes, regulations, expenditures, and guarantees strongly influence the outcome. These governmental influences were all undertaken with certain purposes in mind, but many of them have become outmoded by time and now produce effects inconsistent with the expansion of capital resources. Given the huge capital needs in the years ahead for energy development and retooling of many industries, aside from the needs of a growing elderly population, it is desirable to reappraise how we use our national fund of saving.

A serious drain on the nation's saving has been Federal budget deficits. Although justifed in recessions to stimulate business production, deficits carried over an entire business cycle tend to reduce capital formation. To be sure, some government expenditures are for capital purposes, such as roads, airports, etc., and analysis of the Federal budget should allow for such capital expenditures. It is widely recognized, however, that the Federal deficit has become too large year after year and should be substantially reduced.

Another major effect of public policy on the allocation of saving has been the numerous provisions encouraging home ownership. Promoting home ownership has been the intention of Federal policy and it has provided many benfits. At the same time it has disadvantages which require continuing assessment to see whether we may have carried a good thing too far. We cannot sensibly say that, since home ownership is good, therefore the more the better. To be sure, anyone who wants his own home should be free to invest in it to the extent desired. The question is whether he should be drawn by special tax incentives to invest more in a home than he would otherwise willingly choose to.

By inducing people to channel more funds into housing, we have provided less for other investments, in particular business investment in capital plant and equipment. Such capital is vital: it makes labor more productive and generates a larger output of the products of industry generally at less cost per unit. To be sure, various government measures have been designed to encourage business investment, but under inflation the taxation of this investment appears on net to have increased, and retained earnings of business which finance a large part of its investment have been heavily taxed. The net government influence on business investment, including various forms of regulation, has therefore been negative. It is important in providing tax incentives for saving, therefore, to pay attention to the way incentives channel the uses of the saving.

Even if we succeed in increasing our nations saving it will undoubtedly still remain inadequate to satisfy all the seemingly desirable investments. As the 1981 Annual Report of the Council of Economic Advisers concludes, a continuation of past investment rates, "would not provide for an expansion of capital per worker or for the nation's increased needs for energy investment... the share that investment takes in total output will have to rise substantially from .. 10½ percent or so to 12½ or 13 percent."

Hard decisions of public policy will have to be made, and past incentives to divert saving into particular uses need careful consideration and probably some redressing. A redressing need not necessarily mean taking away all present incentives for the uses of saving, in particular for homeownership, but it does mean removing some disincentives on important other uses, such as business investment in needed plant and equipment.

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the 1981
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Report of the Mini-Conference on Housing for the Elderly

MCR-15

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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Housing

Introduction

On October 22-24, 1980, more than 300 housing developers, reformers, consumers, and advocates gathered at the International Inn in Washington, D.C., for a White House Conference on Aging Mini-Conference on Housing for the Elderly. For three days, they listened to expert speakers, considered problems associated with housing the elderly, and proposed a score of recommendations designed to form a housing blueprint for the '80s. The recommendations covered homeowners, renters, the poor, the frail, and key areas of program administration. In essence the recommendations renewed the call--not yet fulfilled--for a decent, affordable home and suitable living environment for every American.

The Mini-Conference on Housing was one of 20 such mini-conferences on as many different issues taking place in preparation for the 1981 White House Conference on Aging in December. These meetings were designed to focus national attention on special aging issues--issues affecting special populations or issues which would not be treated in depth through the general process of local, state, and regional meetings leading to the national conference November 30-December 3 in Washington, D.C. The Mini-Conference on Housing was sponsored by the National Council of Senior Citizens and the National Senior Citizens Education and Research Center in cooperation with the NCSC Housing Management Corporation.

The National Council of Senior Citizens, the nation's largest organization of senior citizens clubs, has stressed the housing needs of the elderly and handicapped, along with health and income issues, over the nearly two decades of its existence. In 1971, it took the leadership in social and political action to achieve re-establishment of the Section 202 direct-loan housing for the elderly program which had been halted by President Nixon. Through the program coordination and management efforts of the NCSC Housing Management Corporation, the National Council of Senior Citizens has sponsored 14 senior citizen apartment buildings located in both urban and non-urban areas of the country.

Though the NCSC Housing Management Corporation was established, uniquely, to set up management of senior citizens housing on the tenants' council principle, the NCSC Housing Management Corporation's interests are not limited to NCSC-sponsored projects. It also provides professional management of senior citizen housing projects on a nonprofit basis, incorporating services such as recreation, nutrition programs, and senior centers for use by building residents as well as by the elderly in the surrounding community. With strong tenant participation, a supportive environment that encourages independent living is the goal in the buildings managed by the NCSC Housing Management Corporation.

The National Council's affiliate, the National Senior Citizens Eduation and Research Center, a charitable, nonprofit corporation, is mandated to formulate, determine the need for, develop, and implement programs for older Americans.

The Mini-Conference on Housing was organized into four workshops: Development and Financing, Homeownership, Existing Rental Housing and Displacement, and the Physical and Social Environment of the Elderly. The first chapter of this report provides an overview of selected issues, recounting past federal promises and achievements, the housing plight of the elderly, and the response of the meeting.

The report's second chapter reviews the proceedings of the Mini-Conference; its recommendations are detailed in the third chapter.

Recommendations developed at the Mini-Conference on Housing will be sent to 1981 White House Conference technical committees, to all of the delegates, and finally to the national conference itself. The Mini-Conference did not include consideration of nursing homes or intermediate care facilities, regarding them more properly as a resource for health care rather than housing.

Chapter 1 -- A Housing Blueprint for the '80s

Despite more than 30 years of federal promises--and some notable achievements--decent, affordable housing still eludes many of the nation's elderly. And, instead of retreating in dismay, they are renewing the call for a national commitment to stepping up the progress toward fulfillment of the promises.

"A blueprint for the next decade is needed," declared the Mini-Conference on Housing for the Elderly. A score of recommendations emerged from the participants. They stressed five major areas:

- Greater help for homeowners against rising costs;
- Increased protection for renters against displacement;
- Expanded construction of assisted units for the poor;
- Broader choices of housing types and services for the frail;
- Greater information about programs and services for all.

Other areas of recommendations included:

Better coordination among providers, and increased consumer participation in programs, planning, and management.

"There was a general consensus," the Mini-Conference concluded, "that an overriding necessity in meeting the housing-related needs of older people is to promote the development of a continuum of appropriate housing types. The supply of all housing types needs to be expanded. Furthermore, for older people, attention must always be paid to the fact that their homes are more than shelter; the adequacy of the housing environment is a key ingredient to their overall health and life satisfaction. Hence, for them, housing and services must be treated as an integral set of concerns."

According to 1976 data, 20 percent (14.8 million) of the nation's households were headed by someone 65 or older, and their median income was nearly 60 percent below the median for the population as a whole ($10,141 for 65 or over v. $17,640 overall). Despite the fact that nearly three-quarters of the elderly households were owners and most (84 percent) had paid off their mortgages, seniors were more likely than non-seniors to live in modest, older housing, which lacked central heat, air conditioning, and complete plumbing and kitchen facilities. Furthermore, seniors spent more of their income than others for food, health care, and housing, and spent the greatest proportion for housing. Of elderly renters, 40 percent spent more than 35 percent of their income on housing. Most elderly households were comprised either of a married couple (45 percent) or of a woman living alone (33 percent). Most lived in metropolitan areas (33.1 percent in central cities, 30 percent in suburbs). In addition, two percent of all households have an aged person living with a young family. And 5 percent of the elderly are institutionalized or live in other types of group quarters.

Past Federal Promises and Achievements

Federal promises of a decent home and a suitable living environment for every American first appeared in the Housing Act of 1949, and have since been reaffirmed regularly in every major housing bill.

The first National Conference on Aging, a precursor to the White House Conference on Aging, held in 1950, urged housing programs specifically designed for the safety and comfort of the older population. The 1961 White House Conference on Aging called for programs "to create a condition in which the aged will be provided such living accommodations as will enrich their way of life and offer a future to the many who have none." The 1971 White House Conference declared, "A decent and safe living environment its the inherent right of all elderly citizens." And finally the legislation establishing the 1981 White House Conference proposed as a key policy area the "expansion of availability of appropriate housing with supportive services to promote increased independence for older individuals."

Special federal programs for elderly housing started with the Houseing Act of 1956. Previously, the only specialized housing for the elderly had been such facilities as county homes, church-supported homes, federal and state homes for veterans, and privately endowed institutions. The 1956 Act liberalized federal mortgage insurance programs for elderly home buyers, and opened public housing projects to single elderly people.

In 1959, the first federally subsidized private housing program of any kind was enacted; it was specifically designated for the elderly. It was known as Section 101, and it introduced a private direct loan program for housing the elderly. It became the only housing program under HUD which provides a 100 percent construction loan, and it is the only HUD program which is mandated to have all sponsors classified as private nonprofit corporations, organizations, or cooperatives. During the program's history, over half the sponsors have been religious institutions, with the remainder composed of nonprofit union groups, community-based organizations, cooperatives, and fraternal organizations. A 1979 HUD report on the program concluded that "Section 202 has generally produced good quality, cost-effective, and financially viable housing."

Over time, other housing assistance programs were added in which the elderly could participate, and some of these programs assumed major responsibility for housing the elderly. By 1977, for example, more than 700,000 elderly households occupied HUD-subsidized rental units, primarily through public housing (342,000 households), Section 8 rent subsidies (144,000 households), and Section 236 mortgage insurance and interest subsidies (171,000 households). Other helpful assistance programs included rent supplements (5,000 households), Section 221(d)(3) mortgage insurance and below-market interest rates (18,000 households), and Section 202 (36,000 households).

Despite the development and growth of different programs, production of housing for the elderly never matched the 120,000-units-a-year goal set by the 1971 White House Conference on Aging.

The Housing Plight of the Elderly

Fighting double-digit inflation and coping with the degenerative processes of aging are the two biggest hurdles for the elderly. Housing, food, and health care comprise the largest expenditures for the elderly, and the costs of each have risen steeply in the past decade. From 1973 to 1979, food prices rose 60 percent; fuel prices rose 293 percent, natural gas 155 percent, and electricity 75 percent from 1972 to 1979; from 1977 to 1978, health care cost rose 11 percent. Trying to fight such increases on inflation-sensitive budgets, forced millions of elderly households into confrontations with poverty. One estimate held that nearly ten million elderly households qualified as low-income, according to standards applied by HUD (80 percent of the area's median); and that of the total, seven million qualified as very low income (50 percent of the median). A 1979 HUD survey, found that only 59 percent of the elderly could afford adequate housing for the widely recognized norm of one-fourth of their incomes. In addition, the housing occupied by nearly half the elderly is more than 40 years old, and thus is both poorly insulated and subject to high maintenance costs. In rural areas, and for minorities, the situation is even more serious. In 1979, the greatest incidence of poverty among the aged was in rural areas. Sixty percent of the nation's substandard housing is found in rural areas, and one out of four such units is occupied by an older individual. More than half the rural elderly live in homes built before 1915. In 1978, 33 percent of the black elderly and 23.2 percent of the Hispanic elderly had incomes below the poverty level. A Census Bureau estimate put the median annual income for elderly Indians at $1,408, implying that at least 50 percent of the Indian elderly were at or below the poverty level.

For the elderly whose mobility becomes restricted and whose physical acuity diminishes, special assistance becomes essential. Yet obtaining a range of service that is appropriate, while continuing to live in the community, can be a frustrating and burdensome task. Providers are limited, and information about them is inconsistent. Service costs are substantial, and few projects have included them in their financial planning. Without such services, the frail elderly have few choices but to give up their independence and seek admission to a nursing home or similar facility.

The estimates of need are substantial. A study by the Urban Institute of Washington, D.C., suggested that some 2.4 million persons aged 65 and above need appropriate shelter and services to remain outside of institutions. And another study of public housing occupants found that of the 54,850 who needed more assistance than was availble, 43,880 could live in some form of congregate housing that offered an adequate service package. The rest required nuring home care.

Some current providers report difficulty in meeting even a part of the needs. A General Accounting Office study of social services provided the elderly under Title XX of the Social Security Act, for example, showed that providers were not reaching all the elderly who needed services in each of six states in the study. The GAO assessment showed that about 35 percent of the elderly in five states and about 23 percent in a sixth needed three or more services than they were receiving. The kinds of services involved included health-related services, homemaker/chore services, individual and family counseling services, transportation services, and protective services.

Government favor is increasingly turning to service packages for the elderly (in contrast to construction programs) because of their lower cost. As HUD Assistant Secretary Lawrence B. Simons told the Mini Conference, these programs--congregate housing and home maintenance assistance--"would appear to be more cost effective, that is help more people with the same amount of money than re-housing the millions of older persons living in their own homes and not able to afford it."

The Response of the Mini-Conference

The responses of the Mini-Conference were manifold. They addressed issues affecting non-profit and for-profit builders and developers, homeowners, renters, the poor, and the frail, and such administrative areas as information, coordination, and consumer participation. In essence, the Mini-Conference sought to renew the call for assured affordability, additional units, and provision of services.

It declared, "This Conference supports and encourages the adoption of policies which will entitle all low- and moderate-income persons to pay no more than 25 percent of their annual income for housing. Additionally, the administration shall ensure that all federal activities be coordinated to maximize the efficient and effective delivery of service." Further, the Conference stressed the need for greater variety in housing arrangements for the elderly beyond the conventional owner-renter approach.

A summary of the Conference's major recommendations appears below (details are in Chapter 3).

Homeowners: Access to a homeowner's accumulated equity in his or her house should be developed through reverse mortgages and other means to provide a supplement to current income. Operating expenses should be reduced as much as possible through property tax relief, improved weatherization and special utility rates, and access to low-cost maintenance services. Alternative housing arrangements such as house-sharing should be encouraged to improve utilization of the housing stock. Social services should be provided to extend the residence of frail elderly in their communities.

Renters: Renters need increased protection from rising rents and from displacement due to abandonment or conversion to cooperatives, condominiums, or non-residential uses. Additional low- and moderate-income rental housing should be built under new tax incentives, broader government mortgage insurance, and new investment from the private sector. Social services should be expanded to allow renters to remain in their units as their independence diminishes.

The Poor: The government's development of assisted housing should be tripled to about 600,000 units a year for all age groups. Additional low- and moderate-income rental units should be developed by the private sector to relieve the pressure on existing housing. Special emphasis should be directed at rural areas and at areas with large minority populations, where poverty tends to be greatest.

The Frail: More housing alternatives need to be developed, and the delivery of social services needs to be increased. The congregate housing program (in which social services are provided as part of the housing package) needs to be converted from demonstration to permanent status, and should be targeted for 120,000 units a year.

Administrative Concerns: Fair housing enforcement needs to be strengthened to assure that no person is denied housing for discriminatory reasons. Information about housing programs and social services needs to be increased, and the elderly's access to the broadened information needs to be improved. Coordination among housing and service delivery programs should be improved, as should program coordination among different levels of government. The elderly need increased opportunities to participate in the planning, design and management of their housing. And research needs to be expanded into all aspects of housing the elderly.

Chapter 2 -- Report on the Mini-Conference

The Mini-Conference on Housing was held October 22-24, 1980, at the International Inn in Washington, D.C. More than 300 participants took part, representing an ethnic, racial, and geographic cross-section of housing developers, reformers, consumers, and advocates. The Mini-Conference was sponsored by the National Council of Senior Citizens and the National Senior Citizens Education and Research Center in cooperation with the NCSC Housing Management Corporation.

As participants began gathering on the afternoon of October 22, they were caught up in an intensive, two-and-a-half-day process of identifying problems, suggesting causes, and proposing recommendations designed to create a housing blueprint for the '80s. The process was built around a series of workshops on development and financing, homeownership, existing rental housing and displacement, and the physical and social environment of the elderly. Participants selected a workshop of their choice, and then retained it as their special interest throughout the Mini-Conference. Each workshop than subdivided into specialty areas so that in-depth analysis and resulting recommendations could be made.

Four general speakers provided participants with a broad overview of activities and issues in housing for the elderly. Additional speakers addressed each of the workshops.

In introductory remarks, William R. Hutton, Executive Director of the National Council of Senior Citizens, urged participants to develop ideas and suggestions "that can be implemented," and "bring us much nearer that goal of a decent home at rents that older people can afford." In his own view, he said, "we should think in terms of constructing an entitlement program so that housing for the elderly would be a matter of right."

The keynote speaker was Lawrence B Simons, Assistant Secretary of Housing and Urban Development. He reviewed HUD's accomplishments in providing housing for the elderly, stressed the dilemma of trying to meet expanding needs from a restricted federal budget, and explained the Department's search for cost-effective new approaches.

Some of his major points:

° Over 30 percent of all assisted housing is now occupied by a person or household headed by someone 65 or over.

° Forty-five of every 100 public housing units are occupied by elderly tenants.

° Two-thirds of all new Section 8 rent assistance units are specially designed for the elderly.

° Under the congregate housing services program, 55 grants have been awarded in the first two years.

Still, he said, the expanding needs generated by the graying of America and diminishing resources resulting from tighter federal budgets and the ravages of inflation will force "painful choices between what we would like to do and what we can afford to do." And he outlined several efforts by the Department to stretch housing dollars further for elderly homeowners and renters and for the frail elderly. Some of the efforts:

° A $2.2-million home maintenance and minor repair demonstration program designed to serve 750 elderly, low-income families in six cities: Philadelphia; Cleveland; Hot Springs, Arkansas; Greensboro, North Carolina; Boston; and Cincinnati.

° Exploration of ways to support increased use of reverse annuity mortgages (which allow a homeowner to take advantage of accumulated equity in the house to obtain income for operating expenses).

° Funding through the Section 312 rehabilitation loan program, the neighborhood self-help program, and the Secretary's Discretionary Fund to acquire and rehabilitate single room occupancy residential hotels.

° Exploration of ways--such as shallow subsidies, up-front grants, or tax credits--to encourage construction of new rental housing (in anticipation of a shortage of from 100,000 to 300,000 rental units a year over the next decade).

° Support for the congregate housing program as a less costly alternative for the frail elderly than residence in a nursing home.

The other two general speakers were Martin J. Ward, General President of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, and Dr. Morton Leeds, Special Assistant for Elderly Housing and Special Projects, U.S. Department of Housing and Urban Development.

Mr. Ward reviewed the crisis conditions in the housing industry as a whole, called housing for the elderly an inseparable part of the overall picture, and proposed expanded government assistance for the industry.

"The growing scarcity of adequate and affordable housing poses at least as great a threat to society" as the energy or automobile industry crises, he said. "Many Americans, especially the elderly, have been put in a squeeze. They can't afford to buy a home, and they are being forced out of the increasingly scarce number of apartments," he said. "I hope your work will contribute to awaken all of us ordinary citizens to the terrible danger for society of the crisis in housing we face," he said.

Dr. Leeds urged participants to examine their attitudes toward society and to reflect on the effect of their attitudes on the social process. As contrasting examples, he cited the designer who located an apartment's heating controls a few inches above the floor, the expert on housing displacement who could make the victims' voices nearly cry out in his comments; the small investor who damned the oil companies actions on his way to buying their stock for a piece of the action, and the imaginative local official who allowed older persons to work off their taxes in employment at the city hall. "The way I look at it is this," Dr. Leeds said, "A circle is a closed structure, and you can break into it at any point. Take the problem that you are interested in and work on it. You'll be surprised. You're going to break into that circle at some point. Someone else is working on another point, and gradually the circle changes. New issues emerge as you solve one piece of the problem. To do it requires confidence, faith, determination, and a sense that what we're doing is a very important social good. I happen to believe that."

Throughout the Mini-Conference, addresses by major speakers were scheduled in between workshop sessions. The workshops dealt first with the problems in their special fields, then with the problems' causes, and finally with recommendations addressed to the causes. A number of workshops broke into smaller groups to consider particular problems, but recommendations were prepared by each workshop as a whole.

Workshop A: Development and Finance

This workshop was designed to recommend objectives concerning the development and financing of housing for the elderly for the decade of the 1980s. Present policies were examined and evaluated, leading to the formulation of possible future policies. Workshop participants worked in smaller groups dealing with rural development, cooperatives, public agencies, private for-profit efforts and private nonprofit efforts.

Workshop speakers addressed similar special interests. One speaker, for example, reviewed the production record and financial problems of nonprofit sponsors, and called for greater participation by the private sector. He suggested broadening the present direct loan program to include loan guarantees for private developers, and exploration of joint-venture arrangements.

Another speaker asked whether nonprofit sponsors would be able to compete for funds successfully against professional developers. Further, he suggested special help for nonprofits in gaining access to low-interest funds already available to for-profits. And finally, he suggested an important role for nonprofits in developing group homes and other shared living arrangement which would offer virtually no return on investment.

Another workshop speaker, proposed an eight-point program for rural areas. He said Farmers Home Administration (FmHA) programs serving the lowest income people needed to be increased, FmHA staff needed to be increased, and public housing in rural areas needed to be increased. Further he called for tougher targeting of funds for needy families, greater efforts for farm workers and Indian housing, and increased funding for water and sewer grants.

Over and over again, workshop participants wrestled with the twin issues of rising costs and inadequate funds; they seemed to cut across every field: urban, rural; public, private; for-profit, not-for-profit. Also, getting major attention from participants were an information gap about programs, and alternatives, and supports; an absence of support for alternative housing approaches such as adult foster care or congregate housing; and confusion, inconsistency, and delay in government offices and programs.

One group, for instance, called for greater intergovernmental coordination of public programs, budgets, and services to overcome ineffective legislation, self-protective bureaucracies, a lack of coordinated priorities among government agencies, a lack of monitoring of service delivery, vague regulations, and uncoordinated actions by various outside volunteer agencies.

The workshop's recommendations urged new approaches for attracting additional funds, broader support for alternative housing, improved coordination among government programs and agencies, and development of an international information exchange in all fields of aging. (Detailed recommendations appear in the following chapter.)

Workshop B: Homeownership

This workshop was designed to examine problems facing the elderly presently living in single-family homes. Participants considered such issues as alternative occupancy patterns (shared housing, extended families, etc.), access to home equity, and alternative forms of homeownership, such as condominiums, cooperatives, planned unit developments, etc.). Similar issues were explored by workshop speakers. One, for example, described a shared living program she directed; another described a new home maintenance demonstration program.

In describing the shared living program, the speaker explained that it combines a variety of supportive services with shelter. In the program, each person has a private bedroom, a semi-private bath, and shares the living room, dining room, and kitchen with other residents. Each group home has a part-time homemaker, and is supervised by a social worker. After six years, the program consists of 12 leased two- and three-bedroom apartments in three locations housing 32 residents, she said.

A HUD executive described the Department's Home Maintenance and Repair Demonstration for the Elderly which is underway in Baltimore and seven other cities. In Baltimore, where the program is in its third year, about 300 people are served with an average annual cost of $44 for materials and 13 hours of labor, she said. The program was developed by HUD, she said, to take advantage of housing already occupied by the elderly, to broaden HUD's assistance to elderly homeowners, and to overcome the elderly homeowners' limits on income and mobility.

In the workshop's discussions, affordability, alternative housing, and program information emerged as main topics. Participants were concerned not only with rising taxes, utility, and maintenance costs, but also with access to accumulated equity as an additional source of income. There was concern about exploring alternatives to convential ownership, such as shred housing; and about inadequate informtion on services and support systems for elderly homeowners.

Complaining about poor information sources, one group blamed improper dissemination of information at the local level, poor communications and indifference of service workers, lack of incentive for inter-agency coordination, poor use of mass media, duplication of services, lack of attention to individual need, inconsistency in interpretation of regulations, inadequate planning, and agencies' concern with defending their turf.

Workshop recommendations called for property tax credits, greater weatherization efforts, low-cost maintenance programs, development of home equity conversion programs, and greater support for home-ownership alternatives. Additional recommendations urged broader sharing of information and coordination of services, and strengthened mandates for rural housing. (Detailed recommendations appear in the following chapter.)

Workshop C: Existing Rental Housing and Displacement

This workshop was designed to examine policies affecting the amount, affordability, and condition of the existing rental housing stock in which the elderly live. It also focused on the issue of displacement. Workshop speakers covered both topics.

The issue of displacement drew the greatest attention by far. Each of the workshop speakers condemned the practice. They urged broader coverage under the federal Uniform Relocation Act, and stronger measures to reduce private displacement.

Discussion groups agreed there was a lack of affordable rental housing, and proposed both public goals and private incentives for greater production. Their suggestions would nearly triple the number of assisted units, guarantee affordable housing as an entitlement, and place an absolute ban on displacement.

In its recommendations, the workshop called for an increase in assisted housing to 600,000 units for all ages (compared to 202,000 units in fiscal 1980), strengthened fair housing enforcement procedures, and tighter restrictions against displacement by either public or private actions. (Detailed recommendations appear in the following chapter.)

Workshop D: The Physical and Social Environment of the Elderly

The workshop was designed to examine policies concerning the design of new housing for the elderly as well as development of the existing housing stock. In addition, policies concerning supportive services were examined. Both topics were covered by workshop speakers.

One of the speakers stressed the lack of solid information about the actual effects of aging on housing and living arrangements. He said that inadequate information prevented sound policy development and called for greater emphasis on research. Thus, he continued, our primary orientation toward housing should be to stimulate innovations and preserve the living alternatives that presently exist; since we lack clear-cut criteria as to what housing should encompass, new and imaginative concepts should be tried.

In their discussion groups, participants stressed again and again the need for a broader range of housing choices and for greater availability of social services. They also pleaded for greater information about housing and services, for greater participation among consumers in housing design and management, and for expanded research and demonstration efforts.

For instance, one group touched on a number of key points. It maintained that housing and human services must be mutually mandated; that in this way, the rapid deterioration of housing and individuals would be prevented. They made the point that in order to get services, one must be institutionalized; services are linked to place and funding rather than to need; that there should be an expansion of housing and supportive programs between independent living and institutionalization.

Another group picked up a similar theme: A failure exists to utilize alternatives in resolving housing problems, such as repair, maintenance, and renovation of single-family homes; in-home services, in either apartments or houses; congregate or sheltered housing; home-sharing; use of mobile homes.

Another group blamed overall apathy, conflicting community interests, pressures of private and special interest groups, and attitudes toward marginal groups.

The workshop's recommendations stressed an expanded range of housing options and broader access to services through the community. They also proposed a better access to information about housing and services, greater tenant participation in planning and management of elderly housing, and increased support for research and demonstration in elderly housing and service delivery. (Detailed recommendations appear in the following chapter.)

Chapter 3 -- Recommendations of the Mini-Conference

This chapter provides the detailed recommendations of the Mini-Conference on Housing as developed by participants in workshops on development and finance, homeownership, existing rental housing and displacement, and physical and social environment of the elderly. Each workshop held three sessions composed of individual subgroups with a facilitator and recorder.

The objective of the first session was to identify five major problem areas with present policies or lack of policies. Individual participants were responsible for identifying problem areas. After analysis of each, a total of five areas of concern by each subgroup was formulated by a consensus vote.

The second session of the workshops entailed discussion of the underlying causes of the five major problem areas identified in the first session. Again, individuals were responsible for identifying at least one underlying cause. After causes were stated, discussion was held and individual causes were then recorded.

The final session entailed the overall objective of the Mini-Conference, the formulation of five policy recommendations based on the problem areas which had been revealed in the first session. Each participant cited their recommendations, which were discussed by the subgroup. A decision, through consensus or majority vote, determined the five policy recommendations that were reported to the overal Mini-Conference participants at the concluding general session. The recommendations at that time were general in content and reported in a draft format. Each workshop had been limited to no more than five policy recommendations concerning their specific area of concern of housing for the elderly.

After conclusion of the Mini-Conference, the staff coordinated the draft recommendations which had been formulated and mailed a copy of them to each workshop participant. After correlation of participants' comments, the final recommendations of each workshop were formulated. The 20 policy-oriented recommendations of the Mini-Conference on Housing for the Elderly follow below. They have been numerated sequentially with each workshop initiating a set of recommendations identified.

Development and Finance

1. Encourage the development and funding of housing and services to increase real options with a range of living arrangements for the elderly, e.g., congregate housing, cooperatives, adult foster care, shared housing, manufactured housing (mobile homes), supportive services and home maintenance. This should be accomplished within the public, private, and voluntary sectors.

2. Establish by legislation the creation of an independent national and international clearinghouse of information in all fields of aging, incorporating all government agency information (including Housing and Urban Development, Health and Human Services, Agriculture, Commerce) and private research and projects. This would be established under HHS, and all information would be available to the public.

3. Overcome the shortage of flexible permanent financing vehicles for various types of housing needed by the elderly by

° the use of incoming HUD and other government loan repayments and annual budget allocations over a five-year period to establish a revolving trust fund for elderly housing production;

° the encouragement of pension fund investment in various types of housing for the elderly through the elimination of restrictions on pension fund mortgage and equity investments in elderly housing, and through the provision of shallow interest subsidies and tax incentives to stimulate production;

° increasing the responsible use of tax-exempt financing for various types of elderly housing configurations;

° the extension of FHA mortgage insurance for various types of physical spaces for the elderly (congregate, intermediate care, continuum of care, existing housing stock), and requiring FHA-insured losses to be paid off in cash.

4. Adopt legislation to change bureaucratic organizations, to modify or repeal existing policies and programs, and to clarify vague regulations in order to coordinate all public housing policies and programs; to increase funding and technical assistance at the local level (i.e., rural, urban, and suburban); to authorize Farmers Home Administration (FmHA) state directors with discretionary authority to approve rural rental (Section 515), home repair (Section 504), and disaster loans (Section 502); to mandate specialized design and site selection criteria, budgets, and services among federal departments and among federal, state, and local governments.

5. Amend the Section 202 program (direct loans for housing for the elderly and handicapped) in the following ways:

° Provide a mechanism for combining nonprofit and for-profit sponsorship. Under this mechanism, the prime mover is the nonprofit; the nonprofit sponsor would be responsible for operations. This would retain the essential nonprofit strength of the 202 program for programming and operations, and at the same time provide the benefit of additional capital through the for-profit sponsor.

° Integrate the philosophy of the congregate housing services program with the 202 program to permit the funding of facilities which accommodate support services.

Homeownership

6. Take action against taxes, utility bills, and maintenance expenses to halt the rising cost of homeownership.

° Taxes: Broaden property tax credit programs; provide for certain tax rollbacks; and accept in-kind contributions by homeowners in lieu of taxes.

° Utilities: Work toward repeal of taxes on utility bills; encourage weatherization; implement cost-based billing that does not penalize the small (i.e. non-commercial) user; encourage development of low-cost alternate energy sources.

° Repairs: Tap low-cost labor pools, such as students or retired persons; provide funding for crisis expenditures through low-interest loans or grant programs, with recapture provisions.

7. Emphasize and expand existing mandates for rural housing by

° changing the title of the Department of Housing and Urban Development to read Housing -- Urban and Rural Development;

° including specific language in regulations making Indian tribes eligible for all programs;

° guaranteeing representation of all rural and ethnic (including Indian) populations by identity rather than numbers, through special regulations;

° clarifying the words "rural," "urban," and "city" as they are defined in government regulations;

° making the Farmers Homes Administration more responsive to the rural population.

8. Correct the current lack of information and lack of coordination of services and support systems for the elderly homeowners by

° requiring that government levels must publicize all available programs by preparing a master list of these programs on federal, state, and local levels in simple language, and that it be publicized using the mass media. Compliance on a state and local level could be linked as a requirement for funding. On the federal level, compliance could be made a requirement by the Office of Management and Budget;

° requiring that policymakers, especially on the federal level, must serve on a coordinating board or other advisory structure to plan and coordinate efforts. Compliance on the federal level could be linked to the Office of Management and Budget through legislation, such as the Older Americans Act. On the state level, compliance could work through the governor's office as a requirement for funding. On the local level, area agencies on aging could have responsibility for supervising this coordination, which could also be linked as a requirement for funding.

9. Increase the availability and acceptability of housing alternatives such as shared homes so there can be greater utilization of existing housing resources. This can be done by

° directing federal, state, and local funding and policy at the development of shared housing (i.e. co-ops, condominium conversions, single room occupancy dwellings). These increased funding efforts should go toward the total utilization of existing housing through shared housing. However, the use of funds at the local level should be flexible as long as the overall goal is being addressed. Benefits received by home-sharers should not be lost if a person participates in this program (i.e. food stamps, supplemental security income). Homeownership should not be jeopardized by participation in such a program. There should be innovative programs to develop cooperative ownership of the house;

° enhancing the acceptability of home-sharing alternatives by increasing awareness on the part of elderly homeowners and potential homeowners. This increased awareness of housing alternatives could be improved by implementing and evaluating model programs, education, and homeownership training.

10. Encourage home equity conversion programs. A variety of voluntary mechanisms should be developed to enable older homeowners to convert their home equity into income, while remaining in their own homes. To meet the diversity of elderly income needs, these mechanisms should include property tax postponement, deferred payment loans for major home repairs, sale/leaseback arrangements, and reverse (annuity) mortgages. In addition to the basic research and demonstration activities, development efforts should focus on consumer information, counseling, and protection; supply support functions, such as new mortgage insurance products, tax incentives, and secondary market (investment) opportunities; and the interaction of home equity conversion plans with public benefit programs.

Existing Rental Housing and Displacement

Introduction This conference supports and encourages the adoption of policies which will entitle all low-and moderate-income persons to pay no more than 25 percent of their annual income for housing. Additionally the administration shall ensure that all federal activities be coordinated to maximize the efficient and effective delivery of services.

11. Prohibit the displacement of any person from his or her housing unit by direct or indirect action of the public or private sector. Such actions include displacement due to conversion of rental housing to condominiums, cooperatives, and hotels; speculation; and red-lining or green-lining.

12. Initiate and implement tax reforms for the elderly to assist them in coping with rising costs. This shall be carried out at the national, state, and local level, and shall further include tax incentives for landlords to maintain their properties as rental stock.

13. Develop annually 600,000 units of assisted housing.

14. Enforce fair housing laws to assure that no person is denied housing for discriminatory reasons. Additional authority to enforce these laws mut be established, including authority for HUD to issue cease and desist orders were violations exist.

15. Provide affordable housing to all moderate and low-income elderly persons as an entitlement, with an emphasis on low-income persons, through rent control and other measures. This requires satisfaction of comprehensive household needs such as energy consumption, transportation, and accessible health and human services.

Physical and Social Environment of the Elderly

Introduction There was a general consensus that an overriding necessity in meeting the housing-related needs of older people is to promote the development of a continuum of appropriate housing types. The supply of all such housing types needs to be expanded. Furthermore, for older people, attention must always be paid to the fact that their homes are more than shelter. The adequacy of their housing environments is a key ingredient to their overall health and life satisfaction. Hence, for them, housing and services must be treated as an integral set of concerns.

There also was consensus that older people must be allowed to exercise freedom of choice in selecting housing opportunities throughout their life cycle; and that they should not be excluded from needed housing and service programs on the basis of income (either too low or too high).

And finally there was recognition that the housing needs of older people must be appropriately attended to, within the context of broader national housing needs.

16. Improve and expand the range of available housing options which provide a continuum of appropriate alternatives throughout the life cycle. Locations for such housing should be in areas desirable for the elderly.

° Expand the general supply of housing.

° Expand housing and supportive programs between independent living and institutionalization (i.e. homecare and sheltered housing).

° Provide tax credits for families supporting elderly relatives.

° Institute programs which support guardianship and conservatorship of elderly family members to keep them in the community. The federal government should place a high emphasis on retrofitting and maintenance of older individuals' homes to allow them to remain in their own homes.

° Develop and enforce a new (or revised) site selection criterion that takes into account local physical, social, economic, and political conditions.

° Develop legislation or procedures for dealing with and obtaining variances (if necessary) of local land use ordinances that limit site availability.

° Continue use of existing urban buildings.

17. Expand and improve service resources available to older people in all housing types. Housing programs must have human services available with sufficient funds and qualified staff. A coordination must exist between housing services in planned housing, as well as in other living arrangements within a community.

° Coordinate various funding sources by establishing a formal mechanism at the federal level (i.e. a single agency with well trained personnel rather than political appointees). Provide more Health and Human Services, Administration on Aging funding cooperation, such as earmarking. Regroup funding systems so that providers of services do not have to compete for available funds. Coordinate federal, state, and local agencies as well as public and private agencies providing services for the elderly (i.e. community, HUD, and business partnerships).

° Define social services as standard operating cost in housing for the aged. Facilities should be accessible to those residing in housing projects. Develop a funding formula for human services within Section 8 rent assistance and low-rent public housing programs. There should be a minimum of 10 percent of gross residential square feet devoted to community services (5,000 square feet, for example, in a 50,000 square foot building). There should be greater accessibility to the space by the community; and all community space ought to be convertible to other uses. There should be adequate personnel and space for service delivery at the local level. New and rehabilitated housing for the elderly should be designed so that services including counseling and crime prevention can be introduced and provided as the need arises. The "negotiated investment strategy" technique should be used to develop a project service package. There should be coordination of housing and services, and commitment of funds for long-term housing and service in the same time frame (20-year programs, for example, renegotiated each five years). Housing and human services must be mutually mandated.

° The Congregate Housing Services Program should be shifted from demonstrations to a permanent program, and its budget should be increased substantially to support 1.2 million units over the next 10 years. There should be better training at project and HUD area levels on the desirability and utilization of congregate services. Plan for expansion and reconstruction of physical design to accomodate frail persons (e.g. home maker services, sheltered housing, life continuum committees).

° Provide services to homeowners and residents of the community to prevent isolation of the elderly, including transportation and information about available services, such as crime prevention, legal services, home renovation, and retrofitting.

° Encourage tax incentives for services in private, for-profit developments.

18. Improve the means by which consumers and professionals secure knowledge of access to housing and service resources.

° State and federal government should improve the process of disseminating technical and design information to consumers and industry, and provide increased technical assistance. Information should be disseminated about services through public service announcements on radio and television, in local newspapers, churches, clubs, shopping areas, banks, and through special fliers in tax notices.

° There should be an effort to identify possible clients to determine the scope of the universe.

19. Expand the opportunities for older persons to participate in planning, design and management of their housing.

° State and federal government should insure that consumer input is incorporated in the design of facilities.

° There should be a stronger lobbying group for elder affairs.

° There is greater need for tenant participation in decision-making. Tenant education and information should be initiated by management or the supervisory agency, such as HUD field staff. A tenants' clearinghouse could offer technical assistance and leadership training in cooperation with local groups. Tenants should be involved in actual decision-making, rather than serving only in an advisory capacity.

20. Improve and expand the research on housing design--service housing coordination models--and on the adequacy of present housing. Also, improve the means by which the findings of research are made available in usable form to all participants in the field of housing for the elderly.

° There should be research to determine the scope of the problem, the needs, and so forth existing in housing for the elderly.

° Demonstration programs should be directed to multi-family, homeowners, and independent living situations; and the programs should be related to physical design and physical aids for the elderly.

° There should be research on the implications of independence vs. dependence, recognizing the objective of maximum independence for the frail elderly. An ad hoc social service committee should be created in coordination with the Administration on Aging to advise HUD and coordinate physical and social research.

° The housing market research perspective should be evaluated on the need, desirability and permissibility of more two-bedroom units. There is a need for this in the context of broader social service aspects of life styles.

° A task force should be established to review current categorical elements and recommend changes to remove conflicts. Through a formula, perhaps based upon age and population, funds could be provided to localities. The case approach should be used to determine the needs of the client, and payment for services needed should be on a sliding scale based on ability to pay.

° There should be further promotion of intergenerational opportunities in housing.

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Report of the Mini-Conference on the Mental Health of Older Americans

MCR-16

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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PREFACE

The report which follows addresses many of the important issues regarding mental health and aging. It was developed from the Mini-Conference on the Mental Health of Older Americans, held November 17-19, 1980, in support of the 1981 White House Conference on Aging. This mini-conference was particularly noteworthy in that it brought together over 100 representatives from citizens' groups, federal, state, and local government and professional associations for productive collaboration, under the joint sponsorship of the American Nurses Association, the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers. We hope this report fully conveys the sense of dedication and cooperation apparent at the meeting.

The conference was originally designed to examine the mental health needs of seven subgroupings of older Americans, defined along a continuum from the healthy individual living independently in the community to the chronically mentally ill living in institutions. This allowed a broad perspective on the interchange between identifiable service needs, delivery mechanisms and policy issues. For the purposes of this report, those seven subpopulations have been collapsed into three more general groupings: the psychologically healthy, the acutely distressed and the chronically mentally ill.

The purpose of this document is twofold: (1) to provide information on mental health and aging to the delegates to the 1981 White House Conference on Aging; and (2) to offer possible recommendations on public information, prevention, reimbursement policy, service delivery, training, and research. Attention to the matters discussed in this report are critical to better meeting the mental health needs of older Americans in the 1980s.

Mental Health

The mental and emotional well-being of any individual is closely intertwined with many other facets of life, such as physical health, family and social relationships, and financial resources. Problems in one area may lead to mental or emotional difficulties, or vice-versa. This is especially true of older Americans, as the aging process is accompanied in varying degrees by decreasing physical abilities, increased risk of illness, changing family relationships, social isolation, and financial crisis.

The significance of mental health and illness for older Americans is borne out further by some important facts. Overall, some 15-25% of Americans over age 65 experience significant symptoms of mental illness; 50-75% of those elderly residing in nursing homes manifest significant emotional and behavioral symptoms. Although the elderly now comprise only 11% of the national population, it appears they contribute to about 20% of the nation's suicides; 5% of the population over age 65 suffers from senile dementia, and by age 85, the prevalence of this disease rises to 20%; and 10-30% of people over age 65 develop some form of depressive symptomatology.

Despite an increased risk of mental disorder, the elderly are consistently underserved by both private and public mental health providers. Only 4% of community mental health center patients are elderly. Only about 2% of the mental health services delivered by private practitioners are to the elderly. Less than 1.5% of all expenditures for mental health care is allocated to the community-based services for older individuals. Sixty percent of those elderly who are admitted to state mental hospitals have not received prior mental health care.

It is clear that the mental health needs of older Americans are important ones. Since mental health is such an integral part of living, policy decisions must place it on an equal footing with other priorities. Yet the public, mass media, governmental administrators and older Americans themselves approach these problems as if they hardly existed. We have closed our eyes to the mental health problems of the elderly, as though we could wish them away.

The mental health needs of all older Americans are by no means identical. It may be useful, however, to consider those needs in relation to three broad categories of elderly persons: the psychologically healthy, the acutely distressed, and the chronically mentally ill. In such a grouping, the psychologically healthy population represent the majority of older persons -- those who are not experiencing any significant emotional or behavioral impairment. The acutely distressed or impaired population consists of those elderly who are experiencing various types of emotional and behavioral disturbances of rapid onset or recurrence. Finally, the chronically mentally ill population is comprised of those few who remain ill for long periods, sometimes throughout their later years. While these distinctions are not always applicable to each situation, they are helpful in distinguishing three groups who need rather different kinds of services.

As mentioned above, most Americans over 65 years of age are well functioning individuals with little or no evidence of mental disorder. Ninety-five percent live outside of institutions. The vast majority of these people function well and adjust satisfactorily -- even when incurring painful setbacks or losses. Even these elderly, however, have psychological needs which should be met in order to assure continued good functioning. For example, while most Americans accommodate well to retirement, some people feel healthy only when they are working. Yet some may be forced into retirement. For these people, preretirement counseling, alternative employment, and educational opportunities (which permit second careers or useful volunteer work) can be critical for avoiding psychological distress and even mental illness. Good health, decent housing, economic security, and the support of family and friends all increase the chances of good mental health.

A sizable minority of elderly, however, will experience psychological distress, partial dysfunction or symptoms of more serious mental disorder. Some have no prior history of emotional difficulties, whereas others may have a recurrence of a previous problem after a period of stability. A few others may have an acute emotional problem superimposed on a chronic mental illness. Examples of acute emotional difficulties include depression, severe anxiety, memory and mood changes, personality changes, stress reactions, sexual dysfunctions, acute psychosis, and psychophysiological problems.

The third group, the chronically mentally ill, consists of those individuals with chronic schizophrenia, chronic alcoholism and drug abuse, certain paranoid conditions, severe personality disturbances and dementia (what many people call "senility"). The chronically mentally ill present us with something of a paradox. Because of the severity and duration of their illness, they are frequently perceived as the most difficult and least rewarding patients to treat. For that reason, the mental health system has often abandoned them. Yet the chronically mentally ill are clearly in need of assistance -- the kind of help that seeks not necessarily to cure, but to provide effective care.

Among each of these elderly populations, other factors may also be important -- factors that may either significantly affect existing emotional difficulties or influence the type of service needed. These factors include acute or chronic physical illness, handicaps (single and multiple), poverty, cultural isolation, minority status and sexual orientation. Each group is somewhat unique. Their special needs should be considered in developing policy and services.

The elderly, their families, and large segments of society have been deceived by two paradoxical myths. On the one hand, it is often thought that symptoms of psychological distress and cognitive dysfunction are a normal part of aging (and, hence, should be ignored). Yet, it is also frequently thought that such emotional and behavioral patterns are part of senility (and, thus, nothing can be done). Both myths lead down the same unfortunate path: unnecessary human pain and suffering. It is no longer necessary to deny the presence of mental dysfunction. We not only have effective diagnostic techniques, but beneficial forms of treatment for many symptoms and conditions as well --including group and family therapies, insight-oriented and behavioral therapies, chemotherapy, partial hospitalization and day treatment, and milieu therapy. What we need now are the policies, programs and services to facilitate their use and make them available to all older Americans.

How can we meet the mental health needs of older Americans? How can we do so in a period of budgetary constraints and thinning resources? The report to follow will discuss some of the major issues in mental health and aging and present concrete recommendations for action in public information, prevention, mental health financing, organization of service delivery, training, and research. Each section will be introduced by a representative "statement of concern" often expressed by older persons.

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Concern: I'm entering later life, and I am sure there are good years ahead of me. But I need to know more about aging. There are so many different notions about growing old -- it's a bit confusing. How can my family and I know what we'll face in the years to come?

Public Information on Mental Health and Aging

Accurate and interesting public information on mental health and aging can have a highly positive impact on older persons themselves, their families and society as a whole. It can serve to dispel many fears and stereotypes about aging, and can be of great assistance in helping aging individuals and their loved ones understand the cognitive, emotional and physical changes those individuals will experience. The dissemination of such material is important to the older person's understanding of the circumstances under which he or she should consider seeking mental health care.

At this point, however, a widely usable body of information on mental health and aging is not readily available. The lack of information on aging and mental health can be particularly troublesome because of the stigma sometimes attached to needing or seeking mental health care. This stigma can be so intense that individuals sometimes refuse needed treatment that could significantly improve their lives. And, unfortunately, such views are not uncommon among our current generation of senior citizens who often view their problems in nonpsychological terms and assume that seeking assistance may diminish their self-reliance. They may believe that only "crazy people" go to mental health professionals. Moreover, their families may also feel a sense of embarrassment about seeking services either for the older person, or for themselves in coping with and supporting the older person.

In addition to the lack of information, there exists the problem of stereotyping. Currently, there is a general constellation of negative connotations attached to the process of aging. Aging is perceived almost solely as a process of decline and deterioration. The elderly are often viewed as nonproductive members of society who are, therefore, less deserving of adequate social, health and mental health services, and perhaps even of basic respect.

While negative stereotypes regarding aging may be found in abundance, their application and meaning may differ for the psychologically healthy, the acutely distressed, and the chronically mentally ill elderly. It is often assumed that the mentally healthy older person will nonetheless inevitably grow more rigid, pessimistic, and cantankerous with age. In the case of the mentally impaired elderly, whether acute or chronic, there may be an acceptance of mental dysfunction combined with a belief that such problems cannot be treated or the quality of life improved. Cognitive and emotional impairment is not the inevitable result of aging, however, and the elderly are responsive to psychotherapy.

Much stereotyping of the elderly is perpetuated by the news media and entertainment industries, both of which maintain an enormously powerful influence on the daily lives and attitudes of Americans. Recently, considerable efforts have begun to improve this image. These efforts have been supported by federal agencies, lay organizations such as the National Council on Aging (NCoA) and the American Association of Retired Persons (AARP), and the media itself. Yet it is clear that such work is not yet complete. Earlier programs should be built upon, and new attempts made. We recommend:

The Administration on Aging (AoA), National Institute of Mental Health (NIMH), and National Institute on Aging (NIA), in conjunction with the four national mental health professional associations and other relevant national associations, should support programs to translate the current scientific information on all aspects of normal and abnormal processes of aging into forms usable by the general public. Material should include a balance among biological, psychological, and social issues. Special attention should be given to the role of the family in supporting the functioning of the elderly, as well as to the unique needs of the minority aged. Specific plans for dissemination to the mass media, including publications frequently read by the elderly and their families, religious publications, newspapers, mass market magazines, commercial, public and cable television should be made. Such material could also be used in programs offered by adult education programs, aging agencies, and community mental health centers.

The AoA, NIMH, and NIA, in conjunction with lay organizations such as NCoA and AARP, should jointly support programs to describe the most common and inappropriate stereotypes about the elderly and present this information to media journalists, news commentators and entertainment industry personnel. The media should be encouraged not to utilize distorted representations of the elderly. The programs should include specific plans for dissemination of such information through articles in newsletters and journals of relevant professional associations.

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Concern: My life has changed a lot in the last few years. I don't think I've had any problems adjusting, but some of my friends have. What can I do to make sure that I continue to do well?

Prevention, Positive Mental Health, and Early Detection

Good mental health requires the satisfaction of basic human needs -- including having a sense of usefulness, a sense of control over one's own life, and the ability to express and accept love and friendship. This is true regardless of one's degree of physical health and economic well-being. The loss of loved ones, personal physical capabilities, economic resources, and societal roles which occur during the later years may work against the satisfaction of these basic needs.

Fulfillment in later life (and prevention of mental illness) can be improved by a strong social support system, improved or expanded coping skills, and the reduction of unnecessary stress. There are unique opportunities to have a preventive impact with the aged. If preretirement planning, social support programs, and education are allowed to take hold during the years leading up to and immediately following retirement, the need for acute and long-term mental health care for older persons may be substantially reduced. Self-help or peer-help groups may provide help in planning, understanding the illnesses of loved ones, dealing with personal disabilities such as blindness or arthritis, or coping with widowhood or the demands of continued parenting. Religious institutions, senior centers, social clubs, minority organizations, fraternal and service organizations, and labor unions can provide the vehicles for such efforts. The activities that such groups provide can facilitate social interaction and interpersonal support, thereby aiding in insulating the individual against the development of emotional and behavioral problems. Federal, state, and local mental health agencies and aging agencies can and should facilitate the development of such community support networks and self-help groups.

The concept of prevention is not solely applicable to the psychologically healthy, as has often been assumed. For the acutely impaired, short-term treatment and follow-up can have a strong impact toward the prevention of future crises or long-term impairment. Among the chronically mentally ill, efforts to provide therapeutic milieux both in and out of the institutional settings can be of great assistance in forestalling further mental and emotional deterioration.

To promote positive mental health and foster prevention efforts with the elderly, we recommend:

> NIMH and NIA should support demonstration projects, with strong research components, on mental health promotion and mental illness prevention.
>
> The AoA, in collaboration with NIMH, the Department of Labor, industry, and labor unions, should support the development of model programs in both the public and private sectors for counseling preretirement individuals about the emotional and behavioral reactions to retirement. Such programs, in addition to providing information on normal patterns of emotional reactions to such events, should provide training in coping skills for dealing with such eventualities. A specific plan for disseminating information on such programs -- including details of actual counseling procedures, program material, and training materials -- should be made.

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Concern: I've noticed some changes lately in my thinking and in the way I feel about things. Sometimes I don't remember things as well as I used to, and at other times I get down in the dumps for no apparent reason. How can I find out whether these things are a normal part of aging? If something's wrong, how can I get help?

Comprehensive Assessment

Any older person with serious mental health problems should receive a comprehensive assessment which includes attention to social, psychological, and physical factors, as well as an emphasis on the functions of daily life. In old age, physical problems can mimic psychological problems so precisely that to ignore the possibility of biologic factors is to consign many to unnecessary chronic illness. Similarly, psychological stresses and conflicts may also manifest themselves as apparent somatic difficulties. Consequently it is important to establish multidisciplinary teams who by working together can provide the older person with a comprehensive assessment. No simple questionnaire or brief training course can help the untrained caseworker differentiate between a physically ill and an emotionally ill individual. Groups able to perform these initial assessments must be encouraged so that every older American will be able to obtain an adequate evaluation. Assessments should preferably be done by multidisciplinary teams. When the lack of available personnel makes such multidisciplinary work impossible, assessment should be performed by properly qualified professionals such as physicians, physicians' assistants, psychiatric nurses, psychologists, and social workers. Our recommendation follows:

> Federal and non-federal third party reimbursement programs need to provide better support for comprehensive assessment. For example, through incentives such as improved Medicaid and/or Medicare coverage, the Health Care Financing Administration (HCFA) should require that comprehensive assessment of psychological and social functioning and health status be performed by all health as well as mental health service programs whenever they serve elderly Medicaid and/or Medicare recipients.

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Concern: If I should have an emotional problem, is there treatment I can afford that could keep me out of the hospital, or will I necessarily be forced into a hospital? What if hospitalization does become necessary -- could I afford that?

Removing Financial Barriers to Mental Health Care for the Elderly

Older Americans need to know that if they encounter mental illness in their later years, high-quality care will be forthcoming. A number of economic factors inherent in the mental health system, however, seriously impede the older person's access to mental health services. It is in part because of such restrictions, especially in the realm of outpatient care, that elderly individuals often do not seek help for behavioral or mental conditions that might be prevented or forestalled. The lack of relatively inexpensive, short-term outpatient mental health services early on may severely test the resources of both the elderly persons themselves and their loved ones. Worse still, it may ultimately lead to far more costly, unnecessary, long-term institutionalization.

The financial factors in the current mental health system which most prohibit community-based outpatient care exist in the Medicare and Medicaid programs. Both programs are structured in ways which encourage the use of costly institutional care. Limits are placed on specialized mental health services. For example, there is a $250 annual reimbursement ceiling (50% of $500) on outpatient treatment of mental, nervous or emotional disorders -- an amount that has not been increased since Medicare was established 15 years ago. In addition, there is a 50-50% copayment requirement for mental health treatment -- unlike the 80-20% copayment reimbursement which is customary for the treatment of physical disorders. In most cases, the services of psychologists, clinical social workers, and psychiatric nurses are not covered. Such restrictions clearly encourage costly hospital-based treatment in which Medicare payment for one hospital day may exceed the entire annual allotment for outpatient therapy. Further, this policy can compromise clinical treatment and encourage the administering of psychotropic medication, as opposed to psychotherapy. Thus, mental health care may focus primarily on symptom relief (via medication), rather than improving coping mechanisms (via psychotherapy). Moreover, there is a 190-day lifetime limit on private psychiatric hospital inpatient care. Such care is usually less costly than psychiatric care in a general hospital, although there is no 190-day restriction on the latter. Free-standing Community Mental Health Centers are also not routinely eligible for Medicare reimbursement for mental health treatment of the elderly. Further, there is a lack of consistent Medicaid funding for an array of mental health and social services for individuals with emotional and behavioral problems living in the community.

In addition to these governmental restrictions on mental health care, coverage provided by private sector insurers is often lacking in many of the same areas. Reimbursement provisions for mental health care -- particularly for the elderly -- are often constrained with regard to the length of time during which treatment takes place, the amount of reimbursement provided, the location of treatment, and the professional discipline of the providers covered.

Finally, neither public nor private insurance providers earmark coverage specifically for comprehensive assessment of and treatment planning for elderly patients. The lack of such critical procedures often leads to a piecemeal, stopgap approach to the older person's needs. He or she may be seen only once by a provider -- when in fact early evaluation and intervention can prevent more serious difficulties.

In sum, the coverage for mental health care provided by both public and private insurance carriers is arbitrary and discriminatory against the elderly. These hindrances make costly (and possibly preventable) institutional care all the more likely for the mentally ill older person. To alleviate this problem, it is recommended that:

> The $250 per year ceiling in Medicare on reimbursement for outpatient treatment of nervous, mental and emotional disorders be eliminated (or, at least, raised substantially). The copayment for mental health services in Medicare should be replaced by the same 80-20% copayment requirement stipulated for physical health care. The services of all qualified mental health providers should be covered.
>
> Medicare reimbursement for mental health service provided by Community Mental Health Centers, including those that are free-standing, should be covered. The 190-day lifetime limit on private psychiatric hospitalization be eliminated. In cases of reimbursement for mental health care, Medicare and Medicaid should be modified to require comprehensive assessment and treatment planning prior to reimbursement.
>
> HCFA should explore ways of providing, through Medicare and Medicaid, improved and increased reimbursement for partial hospitalization, outreach/casefinding, home visits, and mental health services provided in licensed noninstitutional settings. Where such reimbursement provisions already exist, they should be maintained; where they are lacking, HCFA should attempt to improve them.

Mechanisms beyond those of direct reimbursement should also be utilized to make it feasible to provide high-quality mental health care to the elderly. Utilization of a comprehensive assessment of the elderly and their family support systems, and coordination of the existing array of community-based health and social services, would make it possible for many of the mentally impaired elderly to live and function in the community at a substantial reduction in cost of care and treatment. Incentives and programs should be directed towards families, community programs, employers, professional associations, unions and insurance carriers. We therefore recommend that:

> States require mental health reimbursement provisions as part of all insurance plans purchased by individuals, groups, unions and corporations.
>
> Technical assistance and fiscal incentives should be provided to nursing home administrators and managers of other community residential settings to insure access to all mental health and community services by older people.

The assurance of the availability and utilization of badly needed mental health services for the elderly will only be provided in a systematic fashion when there is motivation and encouragement for all parties -- the elderly, their families, service providers, facilities, industry, unions and insurance carriers -- to make such care available, usable, and reimbursable. The above recommendations offer one approach, albeit piecemeal. The alternative would be a comprehensive national health insurance program with equal coverage for mental health services.

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Concern: If I should need help for a mental or emotional problem, and can get to a mental health center or hospital, how can I know that the people there will be responsive to an older person, and that they will be properly trained to help me?

Professional and Paraprofessional Training in Mental Health and Aging

When the elderly experience an emotional or behavioral problem, it is critical that appropriately trained professionals be available to serve them. Each older person may present special problems which need to be met in different ways. The lack of both generalist and specialist training in the area of mental health and aging has contributed to the current status of the elderly in the health care system: unserved, underserved, and misserved. There is a general lack of understanding of the special mental health needs of the elderly among health professionals. Yet because of the prevalence of mental difficulties among older persons, and because of their expected population growth over the coming decades, the need for trained personnel at all levels, qualified in the area of mental health and aging, is urgent. For professionals already in the general mental health field, there is a need for retraining and continuing education in mental health and aging. And given the extreme underservice of the minority aged, the need to recruit members of minority populations into professional and paraprofessional roles is increasingly apparent; such participation by minorities is essential to the establishment of effective relationships with the elderly mentally ill who are members of those minority groups.

As with many nationwide initiatives the matter of resources understandably comes up -- especially during a time of economic tightness. There is a two-part approach, however, that could be undertaken with very minimal funding. The first part would involve a requirement by the National Institute of Mental Health that all curricula of mental health professionals and paraprofessionals in basic training would contain didactic and clinical components on aging; Institute guidelines could be developed to describe more carefully the requirements involved. The second part of the approach would involve the development of a cadre of experts in mental health and aging who could join university staffs in order to implement effectively the first part, the preparation of mental health generalists to be more responsive and effective in treating the elderly; such experts are essential not only for providing accurate knowledge but for offering better role models in the care of older persons. A two-part approach of this nature could be immediately implemented and could literally be launched at every major training center in the country. Both parts would build upon structures already in place at NIMH. We recommend:

> The existing program of support within NIMH for specialized, in-depth training in mental health and aging within each of the four "core" mental health disciplines -- clinical social work, psychiatric nursing, psychiatry, and psychology -- should be strengthened. Such specialized training must be integral to and build upon basic training in each profession. At least one didactic and clinical experience in mental health and aging should be offered in all undergraduate and/or graduate programs in medicine, nursing, psychiatry, psychology, social work, and other allied health professions, to insure adequate training in mental health and aging. The concurrent development of curriculum material specific to mental health and aging for each of these professions should be undertaken. Such curriculum material should include general issues related to aging and mental health, assessment of patients and their families, the range of treatments available, and follow-up therapeutic procedures. Sections of such curriculum material should address the specialized needs of minority elderly as well as the widowed, blind, physically disabled, deaf, poor, rural elderly, and other special populations. Such curriculum material should address the strengths, weaknesses, and rehabilitation potentials of older individuals. Particular attention should be given to the role of family and community support systems in maintaining and/or rehabilitating older Americans.

In addition to the above recommendations, several other needed approaches should be considered in a comprehensive effort to focus on prevention and health promotion relevant to the mental health needs of the elderly.

Many of the social, mental health, and health services provided to the elderly are adequately provided by paraprofessionals and volunteers under professional supervision. As the use of alternative community living situations with mentally ill elderly gains in prevalence in the coming years, mentally ill older persons will even more frequently be assisted by paraprofessionals. These individuals often have no training in mental health and aging. It is essential that preservice training programs, inservice training programs, and curricula material be developed for the training of such individuals. Elderly individuals should be particularly considered for recruitment into paraprofessional and volunteer service training programs. We recommend:

> Patient care staff, managers and administrators, paraprofessional staff and volunteers in a variety of settings serving the elderly should be given special training for work with the aging. While the community mental health center is a natural place for such training, it should also take place in other locations, such as in community living centers for deinstitutionalized mentally ill older persons, alternative living situations, and service agencies not explicitly designated as mental-health related, such as counseling agencies and multipurpose senior centers, and so on. Such training programs should include basic material and information on psychological, physiological, and psychosocial factors in aging, as well as death and dying.

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Concern: What if I should have several problems? Will I be able to find someone to assist me? Even when I'm fairly sure of what help I need, I sometimes can't find it at all, and at other times there are so many places to go that I end up getting shuffled from one to another.

Service Organization, Coordination and Delivery

The mental health needs of the elderly, like those of other Americans, are best met through a well-organized and coordinated continuum of services. Care can and should be provided by family, friends, volunteer agencies and other informal support networks -- as well as by health, mental health and social service professionals. Such an array of services represents a continuum -- from assistance needed by an individual or family in coping with crises and loss to those services needed for individuals experiencing severe emotional distress or dysfunction. Some examples of informal services useful to many elderly and their families include widow-to-widow support networks, issue-focused peer counseling, and telephone reassurance. For those whose problems are somewhat more substantial, psychotherapy with a trained mental health professional is a preferable option. Finally, the more seriously disabled elderly may need options such as supervised living with in-house mental health care, day treatment (partial hospitalization) or full hospitalization.

Yet, there are currently a number of barriers impeding the effective delivery of such services. First among these is the fact that in many areas, particularly inner-city and rural locales, mental health agencies or providers of any kind may not even exist. Secondly, even when an array of services may be available, there is frequently a lack of coordination among social service, health and mental health providers, as well as between formal and informal services. As a result many older persons are simply not served at all or receive care that is duplicative without being comprehensive. The second of these problems, that of service coordination, is more complex and therefore deserves further elaboration.

Poor coordination of services may be brought on by many factors, including unclear delineation of responsibilities, lack of communication, and lack of cooperation among providers.

The older person with an emotional problem may be shuffled from one agency, facility or professional to another. Services may be inadequate or inappropriate. Even when services are adequate, there may be a lack of follow-up. And even when effective and helpful resources exist, the elderly person and their family may be unaware of them. In addition, though it may seem surprising, professionals and agencies are often unaware of resources that exist in their own communities. Accurate and comprehensive sources of information are therefore a "must" for professionals and agencies in any community.

Furthermore, a person who returns to the community from a hospital or nursing home may find their contact with the mental health system broken. Follow-up contact with elderly persons who have previously experienced minor or major psychological distress is essential to comprehensive continuity of care. A resource/case manager can frequently fill this vital role.

Case management (or resource management) is an essential component for assuring continuity of care. A resource/case manager is a trained individual acquainted with private, community, and governmental health and social service delivery systems and who coordinates service provision so that the older individual receives the most appropriate care possible. Such a person may function in either the mental health system or the aging network.

Since many services are provided to the elderly at both formal and informal levels, communication and cooperation is essential. For example, a volunteer working intensively with a physically or mentally ill older person at a senior center may not be fully informed of the elderly individual's difficulties, because of a lack of communication or cooperation between the senior center and the agency or professional from whom the indivdual has received help. Such a worker should have, with the individual's permission, access to consultation with professionals. Some type of formal or informal agreement of information exchange could facilitate this process.

Statewide responsibility for planning mental health services is often undefined, resulting in confused and disjointed service delivery at the local level. Departments on aging may expect departments of mental health to take a leadership role in helping older people, and vice-versa; or one agency may both attempt to take the lead and embroil themselves in territorial disputes. Here again, agreements are needed that insure both cooperation and the clear separation of responsibilities.

Finally, many federal laws and programs contribute to mental health services for the elderly, including Titles XVIII, XIX, and XX of the Social Security Act, the Older Americans Act, the Veterans Administration, HUD public housing programs, and the recently enacted Mental Health Systems Act. All of these laws and programs need to be fully implemented, particularly those portions dealing with the elderly. In addition, NIMH should insure that the National Plan for the Chronically Mentally Ill is reviewed, approved and implemented at the earliest possible date, with particular attention to the needs of the chronically mentally ill elderly.

It is clear that much needs to be done with regard to the provision of mental health services to older citizens, in terms of both the provision of services and their coordination. We therefore recommend:

> NIMH and the AoA together should encourage state and local governments to insure that a range of services be available for the mentally ill elderly, including the designation of a resource/case manager for those elderly individuals with severe emotional and behavioral difficulties. Both agencies should continue their strong and affirmative efforts to provide model demonstration programs in mental health and aging around the country. AoA and NIMH should delegate teams to give technical assistance to agencies and centers at the local level regarding the establishment of viable modes of cooperation.
>
> The efforts made by the federal aging network to insure cooperation between area agencies on aging, community mental health centers, state departments of mental health and the private sector should continue,

and should be expanded where possible. Such coordination efforts should include the establishment of local and state-level information data bases on resources for the elderly.

HCFA should require that a range of mental health services be provided within all institutional and community programs as a condition for participation in Medicare and Medicaid. HCFA, in providing Medicaid reimbursement for Community Mental Health and other local mental health services, should promote the designation of resource/ case managers to individuals, through an increased federal match to states providing such services.

All state plans concerning aging, social services, health and mental health should require the provision of mental health services for the elderly.

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Concern: What if it becomes very difficult for me to get around? Is there any help I can get at home? What about the burden on my family?

Outreach/Home Health/Homemaker Services

Many older people, even when they need mental health care, are unable actively to seek such help, perhaps because they are handicapped in some way or because financial limitations prevent them from doing so. Others may feel a sense of embarrassment because of the stigma that is so often attached to mental illness. The most active mental health services must include efforts to reach these individuals before their problems become too advanced, so they need not become acute inpatient or mandatory institutionalization cases in the future.

Outreach programs are essential for identifying and meeting the mental health needs of those elderly who do not seek services. They can prevent unnecessary institutionalization, lower overall treatment costs, and have a generally positive impact on the older individual's social and emotional capacities. Moreover, these efforts can often be incorporated into existing community programs which involve large numbers of older people, such as recreational, nutritional, educational, and housing programs. These outreach services may be merged with the resource/case manager concept proposed in the National Plan for the Chronically Mentally Ill and the Mental Health Systems Act.

In addition, home health services, "meals on wheels," and homemaker services are often critical to giving the elderly the support they need to remain in their homes. Assistance to the family and/or significant others is also essential, inasmuch as they often provide help that is important in allowing the older person to remain in the community. We, therefore, recommend:

> The federal aging network, through demonstration projects and cadres of technical assistants, assist community mental health centers and area agencies on aging in developing outreach programs to serve the homebound and otherwise nonseeking elderly. These efforts should make full use of institutions, services and organizations already in existence, such as churches, schools, senior and charitable organizations, elderly housing agencies, home health and homemaker services, and hospital homebound programs.
>
> Moreover, in providing reimbursement for mental health services through Medicaid, HCFA should explore fiscal means of encouraging community mental health centers and state mental health facilities to provide outreach services.

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Concern: What if its becomes too difficult for me to remain at home? Is my only option a nursing home? Are there other places I could go to -- places I could afford -- places that are equipped to meet my needs?

Residential Alternatives to Nursing Homes and Institutions

In recent years, alternatives to nursing homes and inpatient mental health facilities have become increasingly prevalent. They include boarding homes, mobile home parks, foster care arrangements, temporary residences, and congregate living centers. For those elderly who do not need care to the extent provided by costly nursing homes and still costlier mental institutions, such alternative situations may be ideal. Older people residing in those settings, however, still experience at least some degree of health, economic and/or social impairment; it is highly likely, therefore, that the mental health problems of many of these residents will be significant as well. However, many residential and treatment alternatives provide little in the way of assessment and other mental health services. Thus, these residents are underserved. Because it is quite likely that the future will see substantial growth among these alternatives, it is recommended that:

> The aging network and the community mental health system (including their parent federal agencies, the AoA and NIMH) collaborate on the development of residential service models that will (a) assess the

needs of present and prospective clients in terms of health, mental health, and psychosocial resources; (b) make suggestions for contrasting models that would upgrade the amount of care given for mental health and psychosocial needs; (c) develop means for training administrative staff and other personnel in assisting the older resident; and (d) develop guidelines suggesting how potential inhabitants of such residences could be best matched with the mix of challenges and support offered by each residential type.

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Concern: What if I should have to go into a nursing home? I've heard it's hard to find a good one if you have mental health problems. I've also heard that the mental health services in many nursing homes are inadequate.

Nursing Home Conditions and Services

National surveys of nursing home residents have shown that one-half to three-quarters suffer from significant degrees of mental impairment -- in fact, many of the 1.3 million individuals currently in nursing homes are former state hospital residents. We also know that the incidence of mental disorders rises with age, with more frequent and more serious difficulties among those most advanced in age. Finally, a substantial number of nursing home residents are multiply-impaired elderly -- formerly productive individuals whose ability to care for themselves has been compromised by complex and progressive physical and mental infirmity.

However, only a very small fraction of all patients living in nursing homes have access to assessment or treatment by a mental health professional. When treatment has occurred, the mental health problems of nursing home residents have too frequently been underdiagnosed, misdiagnosed, and inappropriately treated.

Yet when adequate mental health services are provided, they can help enormously. The few existing studies of the effects of mental health consultation and treatment programs in nursing homes clearly confirm that such services greatly improve patient care and staff functioning in those facilities. Specifically, programs may produce hoped-for changes in residents' moods and behavior, reduction in the need for hospitalization and, in some cases, a decrease in residents' death rates. Lack of awareness of these contributions, however, continues to impede the use of mental health professionals in nursing homes. Administrators, primary care providers, and aides alike have generally had little experience in work with mental health providers.

Furthermore, although current federal guidelines governing Medicaid reimbursement of nursing homes recommend that all necessary services -- implicitly including mental health services -- be made available to residents when appropriate, no specific regulations are currently in force which spell out when and to whom such services must be offered. In addition, certification and accreditation of a nursing home does not in any way depend on its guaranteeing staff training in psychosocial assessment and management, uses and adverse effects of medications, or interpersonal relations. We recommend:

> Provision of both direct and consultative mental health services should be mandated as part of the certification of nursing homes. HCFA should be responsible for the promulgation of such standards. Restrictions on mental health services in nursing homes should be minimized. The costs of mental health services should be incorporated into the base rates charged in long-term care settings, as is done with certain other specialized services such as rehabilitation medicine and physical therapy. While federal legislation is required to implement this recommendation nationwide, we urge local groups to act to sensitize county and state regulatory agencies to the need.

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Concern: With the many different types of problems that older people confront, there must be much that needs to be known about quality mental health care for the elderly.

Research on Mental Health and Aging

Earlier White House Conferences on Aging have played an important role in advancing research regarding the elderly. The establishment of the National Institute of Aging and the NIMH Center for Studies of the Mental Health of the Aging are directly related to earlier White House Conferences. The research funded through these problems has been exciting and fruitful; however, these programs are small and cannot support all worthwhile proposals.

While there has been a tremendous increase in knowledge regarding the mental health of older Americans in the last twenty years, different areas have developed at varying rates and recent findings have generated new research questions. Moreover, a whole new generation of elderly have passed 65 -- raising new questions and opportunities. Thus, there remains a relative lack of knowledge immediately usable by policymakers and providers. This has ramifications for every aspect of mental health care. Without comprehensive epidemiological data on the extent of mental health service need and utilization, it is difficult for policymakers and managers to make the best use of available resources. Moreover, without accurate program evaluation data, administrators are hampered in their attempts to produce mental health programs that attain adequate levels of success. Finally, without clinical data that distinguishes clearly among different emotional and behavioral problems, practitioners are unable to provide the most effective assessment, treatment planning, or services to the older individual.

Within the main areas of needed research mentioned above, there are a substantial number of subareas which require emphasis and further exploration. They include: alcohol abuse and alcoholism; overuse, misuse and abuse of prescription and nonprescription medication; effectiveness of various therapeutic modalities; success (or lack thereof) of alternative community living situations such as boarding and nursing homes; needs and assets of families in supporting and coping with mentally ill older persons; and clinical syndromes such as Alzheimer's disease, depression, and psychoses.

Research on mental health and aging should be relevant to public policy as well as service delivery. It must be easily available to policymakers, administrators, and practitioners. The research, demonstration, and knowledge dissemination programs of NIMH, AoA, and NIA should be expanded.

> Research on social and psychological factors that affect mental health and influence the course of mental disorders in later life needs to be increased. Studies would focus on understanding late life transitions, gaining more information on the optimal role of families and informal support systems relevant to mental health and aging, and quality of life issues. Studies of comparative "quality-of-life" of the elderly in congregate housing, shared living arrangements, community settings, long-term care facilities, and mental hospitals need to be supported. Studies should be undertaken to determine the impact of institutionalization on the elderly, their families, and the interaction between them.
>
> Further, research is needed on approaches to the delivery of services and alternative ways of meeting the service needs of older people in the community and in institutional settings. In this regard, comparative evaluative data on the effectiveness and the cost-effectiveness of alternative service delivery organizations should be undertaken through collaborative funding between AoA, NIMH, and HCFA. The National Center for Health Statistics should collect more data relevant to the elderly. Information on the clinical outcome, comprehensiveness of services, and costs of services delivered by solo primary care providers, organized care settings, multidisciplinary teams, and solo nonphysician

providers (with consultative back-up) should be examined. Development of various models for the integration of health, mental health, and social services should be encouraged, and such model programs should be comparatively evaluated in terms of their efficacy and cost-effectiveness as well as their ability in expanding the accessibility and utilization of mental health services by the elderly.

In order to further promote the growth of knowledge in mental health and aging, we recommend that the NIMH, NIA, AoA, and Veterans Administration should jointly organize and fund a program for support of research centers concerned with mental health and aging. At least twenty such centers, regionally distributed, should be established. Each center should engage in multidisciplinary research to some extent. There should be an overall balance among biomedical, psychological, sociological, and epidemiological approaches. Optimally, one-half of the centers would reflect a psychosocial and/or systems orientation. Research funding and staffing patterns at research centers should also demonstrate biological/psychological/sociological balance.

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Concern: If I should need mental health care, I would be a bit worried about putting myself in the hands of others, though I know that they would try to act in my best interests. How can I know that my rights and integrity will be respected?

Advocacy

The legal rights of patients in state institutions, community mental health centers, and private psychiatric facilities have gained increasing attention in recent years. On the one hand, many patients depend to varying degrees on professionals for assistance and care. This is particularly true of the acutely or chronically mentally ill older person, who may not be fully capable of caring or making decisions for him or herself, and who therefore needs help and supervision. On the other hand, there have sometimes been abuses of professional privilege that have resulted in both violations of patients' rights and unnecessarily restrictive treatment in inpatient, outpatient and research settings. Both perspectives on advocacy are very important. Professionals need enough discretion to help and care for patients, yet patients need assurance that their rights will be respected. The exploration and development of advocacy systems, consistent and enforceable patients' rights, and limited guardianship should be encouraged. We recommend:

The federal aging network, particularly NIMH and AoA, should explore ways to develop advocacy services that will coordinate programs under the Older Americans Act, the Mental Health Systems Act, and the Administration on Development Disabilities. NIMH needs to support and evaluate both current and new models of advocacy, and to explore various modes of financing such services. Finally, NIMH and other aging agencies need to support and encourage states in revising their bills of patients' rights, as recommended by Congress in the Mental Health Systems Act. The development of models of limited guardianship, to assist those severely disabled elderly who may have difficulty making decisions, should also be encouraged.

Summary

In the period since the White House Conferences on Aging of 1961 and 1971, much has been done to improve the mental health of older Americans. Enormous strides have been made in almost every area, from legislation and public policy, to research, to the delivery of mental health services. Mental health professionals, advocates, legislators and administrators have every reason to be proud of their accomplishments. Yet it is also clear that a great deal of work remains to be done in the years ahead. And unlike those who have forged policy in mental health and aging in the past, we now face an ever greater challenge: maintaining existing efforts, and expanding them where possible, in a period of high inflation and budgetary constraints. Our initiatives must therefore be disciplined; we must build carefully on the foundations established thus far at the federal level, state and local levels and work to increase involvement of nongovernmental groups.

What follows is a brief summary of this report's major recommendations:

- Public Information. A continuing effort must be made at the federal, state and local levels to educate all citizens in a comprehensive and accurate manner about the aging process, and to eradicate negative stereotypes about aging and the elderly.

- Prevention. Mental health promotion and mental illness prvention projects, with strong research components, should continue to receive federal support, and should be expanded if possible. Industry, labor unions, and other bodies should encourage and support similar efforts.

- Comprehensive Assessment. Service providers should be vigorously encouraged to employ comprehensive assessment as a prelude to treatment. Such assessment is important to the provision of care that is best suited to the older person's needs.

- Removing Financial Barriers to Mental Health Care. Current reimbursement policies regarding mental health care by both public and private insurance carriers are discriminatory to such care. The $250 per year ceiling on Medicare reimbursement for outpatient mental health care should be raised substantially or eliminated. The same 80-20% copayment that applies to physical health care should apply to mental health care. All qualified mental health providers and specialized mental health treatment facilities should be covered. Similar efforts are needed regarding private insurance plans.

- Training. The need for trained professionals and paraprofessionals in mental health and aging is urgent and will become critical in the coming years. Federal agencies must continue and expand financial support of training and education in mental health and aging.

- Service Organization, Coordination and Delivery. When and where possible, attempts should be made to improve and increase mental health services to the elderly. Further, existing providers and institutions, both formal and informal, need to strengthen their efforts to coordinate services. Resource/case managers should be trained at the local level to assist elderly persons in obtaining the help they need.

- Outreach. An important part of service delivery is outreach -- reaching and helping older people who do not or cannot seek services for their problems. Outreach is a service which can go an extraordinarily long way -- it should be encouraged and implemented whenever possible.

- Residential Alternatives to Nursing Homes and Institutions. For those elderly who do not require institutional or nursing care, these alternatives can be ideal -- so long as they are regulated, and so long as they provide or facilitate access to health, mental health and social services. We recommend that model programs exploring and demonstrating the viability of services in such living arrangements be developed.

- Nursing Homes -- Conditions and Services. A tremendous number of older people currently residing in nursing homes have significant mental and emotional problems, yet mental health services in nursing homes remain negligible. Continued efforts must be made to provide mentally ill elderly nursing home residents with decent living conditions and improved mental health care.

- Research. Despite strong gains in our knowledge of mental health and aging over the last 15 years, much remains to be learned -- knowledge which will ultimately be highly applicable to the needs and problems of the elderly. Psychological, social, behavioral and biomedical research must be expanded.

- Advocacy. The rights of the mentally ill elderly must be respected. We encourage the development of model advocacy programs, consistent and enforceable patients' rights, and models of limited guardianship, with a view toward cooperation and respect among client, advocate, and service provider.

ACKNOWLEDGEMENTS

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APPENDIX

Participants in the Mini-Conference on the Mental Health of Older Americans

National Association Representatives

(The representatives' names are listed alphabetically followed by the association they represented, and their place of employment, respectively. If the representative is employed at the association he/she represents, a single listing follows his/her name.)

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Members of the steering committee also served as representatives of the four mental health professional associations.

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the 1981
White House
Conference
on
Aging

Report of the Mini-Conference on Rural Aging

MCR-17

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

RURAL ELDERLY

Green Thumb, Inc.
1012 - 14th Street, N.W.
Washington, D.C. 20005

Meeting Coordinators: Andrea Jean Wooten
Larry Anderson

Owensboro, Kentucky
September 8-10, 1980

East Hartford, Connecticut
September 23-25, 1980

Jacksonville, Florida
October 5-7, 1980

Sioux Falls, South Dakota
October 19-21, 1980

Oklahoma City, Oklahoma
November 12-14, 1980

Sacramento, California
November 23-25, 1980

Mini-Conference Coordinator

Joan Buchanan
White House Conference on Aging Staff

Publications Coordinator

Stephanie Braime
White House Conference on Aging Staff

1981 White House Conference On Aging

Rural Mini-Conference Report

"Each time a man stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope, and crossing each other from a million different centers of energy and daring, those ripples build a current that can sweep down the mightiest walls of oppression and resistance."

Robert F. Kennedy

Why a Series of Mini-Conferences on the Rural Aging?

For decades it has been recognized by rural leaders, rural-based organizations, and particularly by rural older people that advancing age in rural America brings with it certain unique and important problems that differ sharply from those problems faced by older city-dwellers.

There is an ever-growing number of policy-makers, members of Congress, and leaders in the field of aging who believe that far-too-little attention has been paid to these clearly definable, but extremely significant differences, between growing older in a *rural*, rather than an urban setting.

This series of grassroots Rural Mini-Conferences was convened as a major step in provoking nationwide thought, stimulating national discussion, and recommending to all levels of government solutions which will become an integral part of the national forum provided by the 1981 White House Conference on Aging.

It is clear that the mini-conference process has given tremendous opportunity to single-out and thoroughly examine important rural aging issues, and to recommend new and better ways to make the 1980's a decade of progress for *all* older Americans . . . urban *and* rural.

Some Important Facts You Should Know:

- Over one-third of our nation's elderly (60 years plus) live in rural America.
- 19% of the older rural population exists with a level of income below the poverty guidelines.
- Two-thirds of all sub-standard housing in the U.S. is in rural America, much of which is occupied by older persons.
- Public transportation is nearly non-existant in rural America—greatly affecting the ability of older persons to get to needed services, or to receive proper and timely medical care.

- Many programs and services currently available under the Older Americans Act do not reach rural areas or serve geographically isolated older persons.
- Lack of nearby medical care often means older persons go untreated or make long, expensive journeys to urban medical facilities, if they are able to get transportation.
- Full or part-time jobs for older rural persons are limited, giving little opportunity for supplemental earnings.

Rural America and its people truly are "Coming of Age" and we can ill afford to allow apathy, insensitivity, or ignorance to spawn a new breed of forgotten Americans. Nor can we allow inattention or misdirected programs and services to perpetuate the misery and frequent human tragedy which befalls many rural people as they advance in years.

These rural mini-conference then, represent a new beginning and a fresh start into the next decade, forged by people who care, and by people who believe that the highest quality of life America can offer should extend from birth to death . . . for all people . . . wherever they chose to live.

How Were the Rural Mini-Conferences Convened?

Green Thumb, Inc., a rural-based national aging organization under the sponsorship of National Farmers Union, was designated by the Executive Director of the 1981 White House Conference on Aging, Jerome Waldie, to serve as the official convener of the Rural Mini-Conferences.

The Green Thumb Organization was selected as the convener because of its demonstrated years of concern and experience in developing and implementing programs and services tailored to meet the needs of older rural people. Operating programs in 45 states, Puerto Rico, and the District of Columbia, Green Thumb had the nationwide capability and administrative network necessary to undertake the organizational planning and provide the logistical support required to convene the Rural Mini-Conferences.

How Many Rural Mini-Conferences Were Held and How Were They Financed?

Six Rural Mini-Conferences were held on a regional basis as follows:

I.	September 8-10, 1980 Owensboro, Kentucky
Serving:	Kentucky, Indiana, Virginia, Illinois, Ohio, West Virginia, Michigan
II.	September 23-25, 1980 East Hartford, Connecticut
Serving:	New York, Delaware, New Jersey, Pennsylvania, Maryland, Vermont, New Hampshire, Maine, Massachusetts, Connecticut, Rhode Island
III.	October 5-7, 1980 Jacksonville, Florida
Serving:	North Carolina, South Carolina, Georgia, Alabama, Mississippi, Florida, Puerto Rico, Tennessee

IV. October 19-21, 1980
Sioux Falls, South Dakota

Serving: North Dakota, South Dakota, Minnesota, Wisconsin, Iowa, Nebraska

V. November 12-14, 1980
Oklahoma City, Oklahoma

Serving: Arkansas, Kansas, Louisiana, Missouri, New Mexico, Oklahoma, Texas

VI. November 23-25, 1980
Sacramento, California

Serving: California, Washington, Oregon, Montana, Wyoming, Idaho, Nevada, Colorado, Utah, Arizona, Alaska, Hawaii

Financing for the Rural Mini-Conferences was made possible through a series of unprecedented interagency agreements which pooled monies from a host of federal agencies having responsibilities toward the elderly in rural areas.

The following federal agencies participated in, and provided financial assistance to the Rural Mini-Conferences:

1. The United States Department of Agriculture;
2. The United States Department of Labor;
3. The United States Department of Housing and Urban Development;
4. The United States Department of Health and Human Services;
    - Health Care Financing Administration
    - Health Services Administration
5. The Appalachian Regional Commission;
6. The United States Department of Transportation;
7. The Community Services Administration.

These agencies which provided financial support, along with literally hundreds of locally-based Community Action Agencies, Area Agencies on Aging, Universities, civic and social service agencies that staffed and gave technical assistance, made the Rural Mini-Conferences possible, and made them work.

How Were Participants in the Rural-Mini Conferences Selected?

Conference participants were essentially comprised of two groups:

1. 650 Delegates—whose expenses were paid through Mini-Conference funding, after meeting certain eligibility criteria, and being screened and officially selected by a state Rural Aging Task Force.
2. Non-Delegate participants—represented agencies and organizations, or who were simply interested and concerned local citizens. Non-Delegate participants primarily represented the network of social service professionals providing a wide range of services to the rural elderly. All Non-Delegate expenses were borne by each individual.

Green Thumb, Inc. serving as the Rural Mini-Conference convener, was responsible for the establishment of a "Rural Aging Task Force" in each state. The "Rural Aging Task Force" was composed of a wide range of local, state, and federal representatives whose primary purpose was to fairly screen and select from among the eligible delegate nominees in each state, a representative number of delegates who could articulate the needs, and act in behalf of the rural elderly of their respective states.

Criteria For Delegate Selection

Rural Mini-Conferences

1. The delegates shall be selected by a State Rural Aging Task Force coordinated by the Green Thumb State Director. The composition of the Rural Aging Task Force will be at the discretion of the Green Thumb State Director. The WHCoA State Coordinator, a representative from the funding agencies, a representative from the State Aging Network, as well as representatives from other organizations, agencies, churches and groups concerned with RURAL aging issues should be invited to participate as Task Force Members.
2. The method for selecting delegates to the Mini-Conference shall be determined by the Rural Aging Task Force. (Delegates may be nominated and selected by the full Task Force, or organizations/groups represented may be apportioned delegate positions to fill, etc.)
3. The state delegation must meet the following criteria:
   - 100% Rural
   - Majority women
   - Geographically distributed within rural areas of the state
   - Reflect minority representation as based on the percentage of minorities in the state rural population
   - Majority low income (using SCSEP guidelines)
   - 90% age 55 or older
   - Represent both small town and on-farm living
   - Diverse backgrounds (educational and occupational)
4. Delegates should be able to articulate the needs and problems of the rural elderly in the context of group discussion.
5. Delegates should be willing to travel to the site of the Mini-Conference alone. If not alone, the Green Thumb State Director shall identify and arrange for a responsible person to accompany the delegate to the conference without additional expense to the conference.
6. Delegates should complete all pre-conference questionnaires and forms, and submit them in a timely fashion to the designated office.
7. Delegates should be able to provide reports on the Mini-Conference once that conference has concluded.

What Process Was Utilized to Examine Rural Issues and Develop Recommendations?

All Rural Mini-Conference Participants were involved in intensive discussion in small group workshops. Problem identification within each issue group utilized a process of brainstorming, consolidation, and prioritization.

Participants were encouraged to "dream a little", . . . to think what life should and could be like under ideal circumstances. This helped in determining "action steps" necessary to move from the present state of rural programs and services, to where we *ought* to be as a nation within the next decade in addressing needs of the rural elderly.

Finally, solutions were recommended and resolutions adopted for the purpose of guiding local, state and federal policy and lawmakers as they attempt to understand, develop, and implement workable new approaches to enhance the quality of life, and to assure preservation of the dignity and independence of older, rural Americans.

This 1981 White House Conference on Aging holds a promise . . ., a promise of renewed hope . . . a promise that individual effort can and does make a difference. And thus, this series of Rural Mini-Conferences, along with the following recommendations, *provide a staging area for action, and fulfillment of a national promise and commitment to rural America through the Older Americans Act.*

Recommendations for Action

The following recommendations are the product of the considered thought, research, hard work and long hours of nearly 2000 dedicated rural leaders. Their toil was a labor of love . . . but is only a small manifestation of the dedication and determination to make their dreams, hopes, and aspirations a reality for older rural Americans. *They deserve and will accept no less.*

By way of *Resolutions* adopted at each of six Rural Mini-Conferences, recommendations were made as follows:

TRANSPORTATION

In rural America, mobility is vital. Transportation, or more often a lack of it, affects literally every area of rural life.

For the elderly, the ability to move about can be as important as life or death. Transportation for the elderly can mean living life to its fullest, or without it, living a lonely existence in exile by circumstance, isolated from friends, church, health care, work, shopping and other important and needed services.

No one item holds the solution to so many pressing rural problems as does having adequate, affordable public transportation. Hardly a meeting or conference convenes to discuss rural issues or problems that does not define transportation as the number one problem to rural inhabitants.

For the elderly who do not own a car, and over fifty-percent do not, some form of public transportation is essential to the maintenance of independent living. Without transportation, many older rural persons who could, and would work, cannot, simply because they have no way of getting to and from a job. Many others are institutionalized because access to health care is vital, and without transportation relocation becomes necessary.

Furthermore, so often the many elderly in rural areas who enjoy good health are confined to their homes because they do not own a car, cannot afford to drive a car, or simply will not drive.

A great lack of understanding seems to exist within government at all levels, of how important mobility is to the overall economic and social health of any given area or community. Particularly, many federal officials and lawmakers seem to still hold the mistakened belief that a cross-town bus stops at every street corner across America.

Rural older people know how important transportation is to their well-being, and local officials know too, that transportation is often the *one* ingredient that makes all other programs or services work.

Why then is an affordable public transportation system so elusive, yet so needed? Mainly, because few seem to understand the problem, and fewer yet seem to care about devising a national solution.

Steps have been taken-halting steps at best-but much remains to be done to begin an all-out attack on the problem that is at the heart of rural America's future.

The Rural Mini-Conferences made the following recommendations on transportation to improve the lives of the rural elderly:

- Every effort should be made to provide education, intense technical assistance, and a more clear interpretation of federal and state regulations, in order to encourage local applications for assistance in establishing integrated rural transportation systems.
- A Rural Mass Transportation Administration should be established within the U.S. Department of Transportation, which would coordinate, plan, develop, and finance rural transportation systems throughout rural America.
- Greater coordination should occur between the Federal Highway Administration and the Urban Mass Transit Administration, as related to rural transportation programs.
- Re-examine state insurance options and rates offered by individual insurance carriers to maximize the utilization of public, voluntary, and religious sector transportation systems.
- Extend coordination efforts between the Department of Labor, Federal Highway Administration, and the Urban Mass Transit Administration to provide innovative demonstration efforts in rural public transportation.
- Where possible, encourage the development of regional public transportation systems in rural areas, with emphasis on multi-community cooperation.
- Encourage the development and initiation of privately owned transportation systems in rural areas through low-interest loans on capital and equipment, through tax incentives, and through cooperative relationships between local government and private business.
- Direct a proportionately fair share of transportation dollars from federal and state sources toward rural areas.

- Waive match requirements in those rural areas which are unable to raise enough local dollars to receive federal funds.
- Assure that in all planning of rural transportation, provisions are made for use by the elderly, and that route structuring takes into consideration the transportation needs and geographical locations of rural elderly persons who often are unable to get to pick up points far from their homes.

EMPLOYMENT

"No man needs sympathy because he has to work . . . . . Far and away the best prize that life offers is the chance to work hard at work worth doing"

Theodore Roosevelt

Many real and artificial barriers exist which serve to prevent older, rural workers from extending their work years beyond previously traditional retirement age. Re-entry into the work force, or entry at a later age, becomes nearly impossible for rural older persons wishing to work.

Older women, or widows who may have raised a family and who have been homemakers, often are rejected by employers as "not having enough work experience." Problems are compounded in rural settings where jobs are scarce and public transportation is unavailable.

Rural job seekers who are older face multiple difficulties created by generally fewer jobs, poor or non-existent public transportation, lower wage scales, and a shift or decline in the types of jobs for which they may have been trained or experienced. Jobs in agriculture, forestry, or agriculture-related fields are steadily declining due to both economic factors and mechanization.

Traditional barriers to the employment of older workers are also more prevalent in rural areas where age discrimination is often overlooked or ignored.

As a nation, we are beginning to recognize the tremendous contribution which the skilled, experienced, and willing hands and minds of older workers have made and can continue to make in our economy. Programs like Green Thumb and Senior Aides have demonstrated ways in which this vast national resource can be applied to make our communities a better place in which to live, work, and play.

We simply must learn new and better ways to unleash this vast, untapped resource, and to extend productivity and financial independence into later life.

To that end, Delegates to the Rural Mini-Conferences made the following recommendations:

- The *federal government serve as the employer of last resort* and expand job opportunities in rural areas through the Senior Community Service Employment Program (Title V of the Older Americans Act) and C.E.T.A. Public Service Jobs Programs. Fewer than one percent (1%) of eligible workers are currently given the opportunity to work.
- Establish integrated, workable public transportation systems in rural areas to enable older persons to seek and accept work.

- Develop incentives for local, state, and federal governments to take the leadership in developing part-time, time-sharing, and flexi-time work schedules, and encourage the private sector to follow the example.
- Examine practices in Employment Service Offices to assure that rural areas are adequately served, and that older workers are identified and given counseling assistance. The establishment of an "older worker counselor" has proven extremely successful in limited pilot efforts. This concept should be expanded into rural Employment Service Offices to enhance understanding of the special needs of older rural workers, and to lessen intimidating experiences when the age difference between counselor and client is great. Older persons respond to "peer counseling" when assisted by a counselor of similar age in seeking employment.
- Encourage the private sector to employ substantially greater numbers of older workers through the use of tax incentives.
- Lift social security earnings limitations to provide incentives for older workers to continue working, earning, and contributing.
- Expand loan programs and technical assistance available through Farmers Home Administration and the Small Business Administration, and earmark resources for older persons wishing to become self-employed, or to enter private business.
- Extend vocational rehabilitation benefits to older workers in order to provide assistance with dentures, eyeglasses, hearing aids, and prosthetic devices necessary to seek or continue gainful employment.
- It is now clearly recognized that *functional* rather than chronological age is a better measure of when an employee should disengage from the labor force. Funding should be provided for national research and development of *functional criteria* for measuring employee ability to continue working, in order to prevent arbitrary age-based forced retirement.
- Develop usable, understandable Affirmative Action Guidelines for public and private employers in implementing the provisions of the Age Discrimination in Employment Act. These guidelines should be clear, monitorable, and enforceable under law.
- Eliminate all upper age limits under the Age Discrimination in Employment Act.
- Provide funding through the Administration on Aging and the U.S. Department of Labor for the conduct of nationwide educational efforts to create better understanding of the value of older workers among employers, potential employees, and the general public. Such educational efforts would include private-sector employment demonstration projects including the establishment of private sector job banks and employment placement services for older workers in rural areas.

HOUSING

Housing problems among the rural elderly are acute and often tragic in human terms. Many elderly rural persons are living in sub-standard housing with inadequate plumbing or sewage facilities, or none at all, and many still have unsafe sources of drinking water. Sixty percent (60%) of all our nation's sub-standard housing is in rural America, and one of four such homes are occupied by an older person or family.

Many rural homes occupied by older persons were built over fifty years ago and are inadequately heated or insulated, and in hot weather climates, homes oftentimes are poorly insulated and have no cooling system. Thousands of older persons die annually from cold or heat, preventable by proper, and relatively inexpensive, weatherization treatment.

For older homeowners with often low and fixed incomes, simple maintenance, as well as skyrocketing energy costs, are an enormous drain on limited financial resources. Many older rural persons must choose between fuel or food during winter months, and for many, the choice is tragic.

There is clear evidence of severe national neglect of rural areas in the allocation of resources to finance new, low-cost rental, or owner-occupied housing.

Congregate housing for the elderly in rural areas still lags far behind metropolitan areas in the number of per capita units available. Still worse, there exists no national plan or timetable to approach this serious problem in an organized, efficient way. Great confusion has been created, in part, by overlapping federal agencies, inconsistent financial guidelines for low interest loan and rent supplement programs, and even by different and unrealistic definitions of the term "rural" among agencies administering housing programs in rural areas.

Mortgage money for owner occupied housing is often scarce in rural areas, as is financial assistance to private developers for the building of multi-family housing, affordable to low or moderate income older persons.

Furthermore, development costs are often prohibitive in rural areas. This, coupled with typically smaller developments, often serves as an economic dis-incentive to developers, even though the need exists and is real for many ill-housed older persons.

Delegates to the Rural Mini-Conferences made the following recommendations toward the solution of rural housing problems:

- Substantially greater funding should be provided through H.U.D. and F.H.A. to finance rural congregate housing with multi-service facilities incorporated into the design.
- Expand weatherization programs in rural areas for both summer and winter, including alternative energy-efficient heating and cooling methods and the installation of insulation and infiltration prevention materials.
- Expand and effectively utilize Farmers Home Administration money, and rental assistance programs. Extend the use of program funds to mobile homes.
- Transfer weatherization funds and administrative authority for those funds from the Department of Energy back to the Community Services Administration to improve the effective use and delivery of program resources.
- Develop consistent standard eligibility guidelines to be used by all federal agencies in determining income eligibility for rental assistance programs, low-interest housing loans, weatherization assistance and other housing-related programs serving the elderly in rural areas.
- Develop a national housing policy, with a plan and timetable for providing orderly and equitable distribution of housing resources and assistance to rural areas.

- Provide consumer housing guides and information about available housing programs for use by the rural elderly.
- Develop tax adjustments for the elderly to decrease tax burdens with age.

NUTRITION

"Man has but one body in which to house the existence of an entire lifetime. Therefore, the care which one takes of his body to a large extent determines the quality of his existence here on earth . . ."

For all of us, the ability to remain healthy, independent, secure, and productive depends greatly upon an accurate knowledge of proper nutrition, as well as upon the availability of nutritious foods and supplements, and our access to them. Indeed, without a nutritious diet, good health and both physical and mental well-being cannot be obtained.

Proper nutrition is essential for normal organ development and functioning, for normal cell reproduction, growth, and maintenance; for optimum activity level and working efficiency; for resistance to infection and disease; and for the ability to repair bodily damage or injury. Therefore, every effort should be made to attain and maintain an adequate, balanced daily intake of all necessary nutrients throughout life.

Unfortunately, the opportunity to obtain a balanced, nutritious diet is not one enjoyed by all older Americans today, because of a variety of factors, which include: insufficient nutrition education; limited or fixed incomes with which to purchase dietary requirements; unavailability of nutritious foods and vitamin/mineral supplements; insufficient funding for congregate and home-delivered meals, as well as other nutrition services; and limited access to nutritious foods and health services, where available.

For the rural elderly, these problems are compounded by the oftentimes great physical distances separating the elderly consumer from the service and by the lower economic tax base of rural communities with which to support nutrition projects. Furthermore, the overall higher cost per unit of nutrition services to rural residents, as opposed to their urban and suburban neighbors, contributes to a lower percentage of funding, development, and delivery of nutrition services to rural areas.

Certainly, proper nutrition is considered to be an essential technique of "preventive medicine," as well as a necessary ingredient for the effective treatment of health-related problems.

In Rural America, where health services are inadequate to meet the needs of its citizenry, preventive health care is of great consequence to the physical and mental well-being of older citizens. Good health in one's later years may mean the difference between living independently in one's own home, or being institutionalized in unfamiliar surroundings. It may mean the difference between financial independence or dependence, between happiness or despondency.

The opportunity to obtain nutritious meals, both congregate and home-delivered, is an opportunity of life-giving and life-sustaining proportions to thousands of rural elderly. Because proper nutrition was recognized as being so vital to an active, satisfying life as one grows older, Delegates to the Rural Mini-Conferences recommended that:

- A qualitative measure constituting one-third of the daily minimum nutritional allowance should be required for daily meals provided in congregate facilities and to the homebound.
- Processed foods should be clearly and simply labeled for nutrient value.
- Realistic, expanded funding should be earmarked for rural senior nutrition and social service delivery programs, taking into consideration and uniquely rural problems of physical isolation, as well as the corresponding higher cost of service delivery to rural area residents.
- Social services which were allowed to be budgeted with nutrition money until FY '81 should be reinstated with adequate monies allocated for those services.
- Restrictions on the use of Medicare, Medicaid, and Food Stamps should be lifted in order to allow the purchase of vitamins and other nitrition supplements by the needy elderly.
- Explore alternative service delivery modes appropriate to meet uniquely rural needs such as mobile grocery stores.
- Expand home-delivered meals to include frozen, canned, and shelf stable goods, as well as nutritious snacks served with meals to be eaten later in the day.
- Increase coordination of funding, development, and delivery among responsible agencies and organizations in order to best meet rural needs.
- The Federal Government should reexamine the total nutritional needs of the rural elderly and the hungry, and through a coordinated government effort, mail Food Stamps directly to rural elderly residents.
- Remove legal restraints to allow for full utilization of USDA excess commodities by charitable and non-profit organizations/groups; advocate alternative processing techniques using volunteer labor through gleaning and in community canning centers.
- In order to most effectively meet the nutritional needs of the rural elderly, meals should be served three times a day, seven days a week in nutrition sites with no limit on the number served. Home-delivered meals should be available to meet the needs of all who are unable to eat at the congregate site, with no limit on the number served.
- The Federal Government should examine ways in which rural transportation funds are allocated and delivered; eliminate uniform transportation delivery statutes for urban and rural areas in order to allow for maximum flexibility to meet existing local needs; and require transportation vehicles to be equipped for the handicapped.
- A sliding scale for income eligibility should be examined as a means by which scarce resources may be targeted to those most in need. However, factors relating to emotional stability, physical well-being, and independent living should also be considered in defining those "most needy."
- Health and first-aide training should be provided to nutrition site and outreach personnel in order to enable them to respond quickly and effectively in emergency situations.

- Increase federal monies available under Title III of the Older Americans Act to provide nutrition education and counseling, in addition to adequate and accessible congregate meals and home-bound delivery for the rural elderly.
- Federal policies should encourage and support local community involvement in providing resources, facilities and services for food purchase, preparation, and delivery, as well as nutrition education information and counseling for older rural residents.

ENERGY

A national problem of no small consequence, the problem of energy and skyrocketing energy costs strikes first at those most vulnerable and least able to pay . . . . the rural elderly.

Dependent on costly, private transportation, held captive to the price of oil, gasoline, or other sources of energy transported far from metropolitan distribution centers, and more than likely living in poorly insulated housing, the rural elderly are often the first victims to see and feel their fixed incomes being eroded by inflated energy costs.

The rural elderly often occupy housing which is least energy-efficient and in need of insulation, weather stripping, and other energy-related improvements. Consequently, an ever-increasing percentage of available household income must be spent on heating or cooling energy costs.

Home energy costs are often the least variable of household costs among the rural elderly, as the elderly tend to occupy their homes during most hours of the day, and are unable to alter temperature settings to more energy-saving levels for extended periods. Because of their low-incomes, elderly households are among those least able to afford home improvements which would reduce energy bills.

Energy Crisis Assistance Programs and weatherization programs are currently inadequate to meet existing needs, and often are not extended to isolated rural areas for reasons of higher cost-of-delivery, or because the rural elderly are often unaware of available assistance.

Immediate recognition of the problem, coupled with decisive action, is needed to avert further suffering, and all-too-often choices between fuel or food by financially overburdened older persons.

Delegates to the Rural Mini-Conferences recommended the following actions to alleviate many energy-related problems among the rural elderly:

- Many older rural residents are uneducated regarding available energy assistance programs, and are in great need of information on energy conservation methods and practices which can help reduce household energy costs. Steps are encouraged for cooperation between utilities and government to develop (a) education programs for standard conservation practices (b) rewards or incentives for conservation (c) outreach efforts for conservation awareness (d) home energy audits.
- Establish uniform and fixed energy rates for home heating and cooling for the elderly based on ability to pay.
- Develop a federal energy stamp program to provide reduced energy costs to qualifying families.

- Develop fair and understandable regulations for energy cut-off procedures.
- Provide regulated weatherization standards for new construction of homes or buildings.
- Provide increased federal funding for the development of reasonably priced energy, and the exploration and research of alternative energy sources such as thermal, water, solar, wind, peat, wood and wood by-products, coal, alcohol, and methane.
- Expand nuclear energy research with emphasis on safety and waste disposal methods.
- Expand energy conservation in transportation through coordinated pooling, better vehicle design, and multi-use vehicles.
- Improve and maintain railroad and waterway systems using bold and innovative approaches in moving people and goods.
- Expand research into alternate living modes such as underground housing, foam construction and innovative congregate housing arrangements.
- Establish elected Public Service Commissions with provisions for public review of utility rates.
- Stop preferential rates for high volume users of energy.
- Re-evaluate environmental regulations to determine where modest relaxation can gain high returns in energy use reduction or cost reduction.
- Mandate through regulation, use of available conservation technology both for new construction and retro-fit on older buildings and homes.
- Rewrite building codes to require use of conservation technology, and enforce through bonding requirements and inspection.
- Greatly expand funds available for weatherization, including financial assistance, conversion of heating systems to more energy-efficient and cost efficient units.
- Make greater use of tax incentives to encourage conservation and to expedite weatherization.

RETIREMENT INCOME/ECONOMIC WELL-BEING

"All of us could retire nicely, without financial worries, in our old age, if we could dispose of our experiences for what they cost us."

Author Unknown

No national promise rings so hollow to many older rural Americans than the promise of financial security and adequate income to meet essential living expenses. One in five older persons in rural areas live below federally established poverty guidelines, and many more are among the "marginally poor". That is, they have a family income which only slightly exceeds the stringent poverty guidelines.

Financial security among older rural residents has often been a lifelong problem. With generally lower wages, few job opportunities, and a declining agricultural economy, many families were unable to save or invest for their retirement security. Others, of course, were not covered by Social Security or because of low earnings, only made minimum contributions.

Nationwide, inflation has eroded the buying power of fixed-income dollars jeopardizing the security of millions who expected to at least be able to meet their housing, food, and utility bills, if not to have financial "peace of mind" in their later years.

Rural older persons, dependent on private transportation to move about, are often forced to face expensive automobile ownership, or substantially higher transportation costs to get to essential health services, stores, and other services often centered long distances from their homes.

In short, being older and being "rural" represents a double threat to individual financial security, and certainly being one of many ethnic minorities living in rural America, adds even a third unfavorable dimension.

In order to assure the financial security of older rural residents, and to promote individual self-esteem and independence, the delegates to the Rural Mini-Conferences recommend the following:

- Amend Social Security laws to provide greater protection for women, particularly widows, and divorced widows. Such changes should include provisions for:
    (1) When a spouse dies, the surviving spouse or surviving divorced spouse inherits the deceased spouse's earnings credits to the extent that credits were earned during their marriage.

    (2) Recognize marriage as an economic partnership, and as such, that homemakers contribute to that partnership.

    (3) Inherited credits would be added to any credit earned by the surviving spouse before, during, or after marriage.

    (4) At age 62 the survivor would become eligible for retired workers benefits. That benefit would be based on (A) inherited credits if survivor has never worked in the paid labor force, or (B) a combination of inherited credits and credits earned by the survivor.

    (5) Disability benefits for homemakers.
- Change inheritance tax laws which penalize women involved in the economic partnership of farming.
- Develop responsive adjustments in Social Security payments which more accurately, and in a more timely way, reflect increases in the cost of living index.
- Social Security benefits should never be less than federally established poverty levels.
- There should be no taxation of Social Security benefits.
- Private pension plans should be transferable.
- Emphasis by the federal government should be toward a more balanced federal budget, along with encouragement of increased individual production according to individual capacity.
- Social Security cost-of-living increases should not affect eligibility for food stamps, medicaid, or H.U.D. rent levels.

- Earnings limitations on Social Security should be removed entirely to encourage continued earning and later retirement.
- Eliminate taxes on savings.

MENTAL AND PHYSICAL HEALTH AND LONG TERM CARE

"Grow old with me! The best is yet to be — The last of life for which the first was made. . ."

Optimistically implying that one's later years should be filled with meaning, purpose and the opportunity to live satisfying, productive lives, these words of Robert Browning point to a sad disparity which oftentimes exists in our country. This disparity is between our dreams of a bright future as we grow older, and the solemn awareness that those dreams are not realized by many elderly Americans because of inadequate basic health care services in the more sparsely populated rural countryside.

The maintenance of one's physical health, and consequently, a system of comprehensive health and long-term care services has long been viewed as a basic right to be enjoyed by *all* American citizens, regardless of sex, age, race, ethnic background, religious or political preference/affiliation. Also to be added to these categories is that of "geographical location", since rural residents possess uniquely different health service problems, conditions, and service delivery requirements than those of urban and suburban residents.

Certainly, for America's older rural citizens, health care services may mean the difference between independence and institutionalization, between dignity and humiliation, between hope and despair, life and death.

On behalf of the almost fifty percent of all rural Americans who live in medically underserved areas, Delegates to the Rural Mini-Conferences recommend that:

A. *Medical/Health Coverage*

- A comprehensive national health care plan should be legislated, financed, and implemented for *all* Americans, replacing Medicare and Medicaid. Pending the achievement of such a plan, the complete range of health care services for the elderly must be provided by expanding the coverage and financing of Medicare and Medicaid.
- Medicare policies should provide coverage for dental, hearing, and vision services; chiropractic services; supportive non-skilled, in-home health services; hospice care; intermediate nursing care; preventive health care; prescription drugs; mental health care; podiatry care; services by all certified medical/health care providers; and protection of patients' rights by service providers.
- Medicaid policies should cover preventive health care; hospice care; adult day care; homemaker service; physical therapy; and mental health care.
- Restrictions requiring the divestiture of assets in order to qualify for Medicaid coverage should be reviewed and liberalized.
- Restrictions which dissuade or prevent family members from meeting the health care needs of their older family members because of insufficient financial inducements or assistance, should be removed, with incentives such as tax credits, funds for custodial care, and home delivered meals made available to families who take care of their own.

B. *Access to Health Services*

- Affordable rural public transportation and ambulance service should be developed and expanded to provide equitable access to medical and other health-related services.
- Legislate and finance additional mobile health care units, day care centers, well-senior clinics, hospice care, respite care, in-home care, home-delivered meals and rural health clinics with health care specialists available on a regular basis.
- Expand health education and preventive care programs for the rural elderly and their families through increased consumer and community planning, coordination, and delivery of services; distribution of information; use of available media and communications systems; and expansion of older worker and CETA programs to implement these programs.
- Eliminate prior cash payment requirement for admittance to hospitals and other health service facilities.
- Establish ombudsmen to assist the rural elderly in obtaining appropriate care, completing health claims, understanding medical care provisions, and alleviating adverse conditions relating to health care needs and services.
- Establish a ceiling on all health costs, including insurance fees for medical care, and prescription drugs.
- Provide incentives which encourage pharmacies to honor Medicaid Cards and prescriptions under Medicare.
- Encourage and expand the availability of rural Health Maintenance Organizations.
- Provide inducements for state and local governments and private enterprise to encourage training and continuing education programs for long term care and other health service providers.
- Incentive payments should be made to rural paraprofessionals; grants to medical students specializing in family practice who are willing to serve rural areas upon completion of training; training in geriatrics to health professionals and paraprofessionals.

C. *Quality of Services*

- Improve quality of nursing home care through regular and stringent monitoring, inspecting, and evaluating of nursing home care.
- The concept of "peer counseling" should be expanded, utilizing trained older counselors within social service agencies to evoke a more effective response among older clients.
- The staff of all social services agencies should be sensitized, through specific training, to the emotional needs of older persons to whom they are providing services.
- Provide funding (federal and state) to make available a continuum of care for the rural elderly ranging from supportive in-home services, through institutionaliza-

tion. Modification of requirements and restrictions governing Titles XVIII, XIX and XX of the Social Security Act, and modifications of Comprehensive Older Americans Act should be made in order to most successfully permit older citizens to remain independent, in the environment of their choosing.

- Legislation should be enacted to redesign the eligibility criteria for Indians to ensure their participation in Social Security benefits; to support health programs for the Indian aged, staffed by Indian people; and to grant relief to Indians who find that they must give up their land, which is sacred, to qualify for needed health programs.
- Encourage better local coordination and communication between medical and home care providers in order to assure comprehensive continuing care and monitoring of health care plans. Local community and private resources should be encouraged.

SOCIAL AND SPIRITUAL WELL-BEING

"There is a destiny that makes us brothers; none goes his way alone, All that we send into the lives of others, comes back into our own."

Edwin Markham

Nothing is so fundamental or important to the quality of life among older, rural Americans than having the opportunity to fully participate in the social and spiritual life of their community.

So often the network of social and emotional support required to make life meaningful, is gained through the associations and fellowship of family, friends, and neighbors, in church, or in community social events.

It is imperative that programs and services be designed which expand upon, and enhance this natural support network.

Delegates to the Rural Mini-Conferences recommend the following:

- Promote an awareness of stereotyping, negative attitudes, and myths surrounding the elderly in our society; develop effective educational, public relations, and intergenerational programs and activities to correct this stereotyping, improve attitudes and erase myths.
- Develop and/or expand educational and informational programs which contribute to improved crime prevention at the local level. Volunteer programs such as "home watch", "alert", and self-defense programs should be expanded.
- Establish more effective and comprehensive consumer protection activities at federal, state, and local levels.
- Institutions of higher education responsible for the education of professionals in medicine, psychiatry, psychology, nursing, the clergy, and social work, should develop within their educational curriculum, a competent of quality geriatric and gerontology education which responds to the special needs and problems of the older population.

- Contribute to in-home family living for rural elderly by increasing SSI and Food Stamp allotments; protecting the family from severe economic loss due to family care of the elderly; provide low interest loans to families for home renovation which enables them to care for their elders.
- Fund volunteer programs in areas of administration, recreation, and management training; provide tax credits to volunteers for hours worked; give priority for additional funding to agencies/organizations which develop and provide volunteer programs.
- Support community programs encouraging "in-kind" contributions and the bartering work exchange concept.
- Enhance and expand the National Senior Companionship Program of ACTION.
- Exempt all drugs and food from taxation for senior citizens.
- Develop effective educational and skill development classes with input from the rural elderly designed to improve self-concepts, employability, and continue the process of life-long learning.
- Utilize the talents of the rural aging in local communities through employment, volunteer activities, on advisor/planning boards and committees.
- Encourage the development of neighbor assistance programs to relieve loneliness among the rural elderly by subsidizing volunteer visitation services.
- Fully fund Rural Development Act of 1972 which provided for industrial, agricultural, and rural community development in order to prevent the flight of rural youth to the cities, due to inadequate rural employment opportunities. The flight of rural youth is presently undermining the informal support system constituted by family and neighbors upon which the old and frail elderly depend for physical and emotional strength and stability.
- Local agencies/organizations should provide assistance in pre-retirement planning to the rural elderly.
- Local churches should provide taped worship services and sermons, conduct prayer meetings, and provide other special ministerial services for the home-bound rural elderly; conduct religious services at nursing homes on the Sabbath and religious holidays; offer volunteer chore and homemaker assistance; provide advocacy, counseling, information, outreach and referral services; offer home-delivered meals to the homebound, the sick, and the disabled.
- Encourage the teaching of the hospice concept, and affirm an individual's right to die with dignity; utilize the elderly in counseling and outreach efforts to bring about an acceptance of death as a natural process.
- Government policies should support and promote the continuation of small family farms as vital to the well-being of the rural elderly, and to the preservation of our national heritage.
- Expand the development of rural multi-purpose senior centers as focal points for the delivery and coordination of needed services for the elderly.

- Enact legislation to aid/or grant relief from the high cost of food, fuel, rent, health, and hospital care, taxes, and the other necessities of life, and ensure that the rural elderly will not become destitute, totally dependent, and subject to the despair of helpness.
- Provide for legislation authorizing speedy prosecution of and severe penalties for those who abuse and commit crimes against the rural elderly.
- Encourage public, private, and parochial schools to incorporate gerontology material in their curriculums and to use older citizens in sharing special knowledge and talents in a classroom situation.

SOCIAL SERVICE DELIVERY AND OUTREACH/OLDER AMERICANS AS A GROWING NATIONAL RESOURCE

"... Have love. Not love alone for one
But man, as man, thy brother call,
And scatter, like a circling sun,
Thy charities on all ..."

Friedrick Von Schiller

The best of programs, in design and purpose, is of no value to those who need it, but who cannot participate. The extension of education, information, and the direct delivery of in-home services are extremely important to older rural residents. No person or family should be denied needed assistance simply because of where they happen to reside. Yet in rural areas, thousands are ignored daily because they live too far from agencies providing services to their not-so-rural cousins, or because rural outreach and service delivery is considered "not cost-efficient."

Scattered populations *are* more expensive and more difficult to serve on a per unit basis, but are those hidden thousands somehow less important or less in need, or somehow second-class Americans because they are rural? Delegates to the Rural Mini-Conferences think not, and they have made the following recommendations for *action:*

- Expand and provide funds for increased advocacy efforts under the Older Americans Act.
- Eliminate federal regulations requiring matching funds for services/programs in rural communities.
- Adjust guidelines for appropriating funds for service delivery to the low-income elderly to reflect changes in the cost of living.
- Mandate federally funded service delivery agencies to provide outreach services to the rural elderly.
- Reimburse mileage expenses incurred by outreach volunteers.
- Increase funding for expanded outreach services and for effective training of outreach workers and planners.

- Mandate State Offices on Aging to hire Outreach and Social Service Delivery Specialists to assist in developing effective outreach guidelines and programs, and to provide technical assistance to outreach workers.
- Require shorter, simpler forms and fewer eligibility reviews for elderly persons by local, state and federal benefit programs.
- Raise non-exempt resource limitation levels for benefit programs.
- Mandate increased intergovernmental coordination between all federal agencies administering programs impacting upon rural seniors in order to assure consistency of interpretation and implementation of rural services and programs.
- Include in the 1981 reauthorization of the Older Americans Act the creation of a separate title for the provision of services to *rural* seniors. This title should have its own separate appropriations, indexed to the cost of living, and should reflect an understanding of and sensitivity to the unique needs of the rural elderly, and the problems which must be faced in order to effectively meet those needs.
- A national focal point to provide representation for the rural aging should be created and recognized by the Administration on Aging and other policy makers which would, for the first time, ensure *Rural Americans* an equal voice in the development of a national aging policy and in the legislative and executive decision-making process.
- The legislation authorizing and regulations guiding rural service delivery should be more flexible in allowing greater participation by the local elderly in determining priority needs, in developing and implementing outreach services to meet those needs, and in determining eligibility for receiving and maintaining outreach services.
- Educate public officials and agencies on the unique differences which exist between the rural and urban elderly - differences which cause rural service delivery to be more costly - in order that these differences may be fairly considered when determining allocations for rural service delivery.
- Local, state, and federal funding allocations for services to the rural elderly should be based on a "needs formula".
- Develop the "traveling van" concept of outreach services which involves transporting medical, mental health, and legal assistance experts to senior centers and private homes to provide information and counseling to rural elderly.
- Require the Older Americans Act and other federal programs affecting the rural elderly to define "Rural Area" as stated in the Rural Development Act of 1972 (PL 92-419):

  "The terms 'rural' and 'rural area' shall not include any area in any city or town which has a population in excess of 10,000 inhabitants, except that for purposes of loans and grants for private business enterprises under Section 304(b), 310(b), and 312(b), (c), and (d). The terms 'rural' and 'rural area' may include all territory of a state, the Commonwealth of Puerto Rico, and the Virgin Islands, that is not within the outer boundary of any city having a population of 50,000 or more and its immediately adjacent urbanized and urbanizing area with a population density of more than 100 persons per square mile, as determined by the Secretary of Agriculture, according to the latest decennial census of the United States."

- Provide telephone reassurance services to rural residents through local sheriff's offices, or by other service delivery agencies, volunteers, or older workers.
- Authorize and fund the research and development of educational materials, programs, outreach and referral systems to address the problems of alcohol and drug abuse among the rural elderly.
- Provide direct funding to the Navaho Nation and other supportive Indian tribes under the Older Americans Act for the delivery of social services in order to improve the physical, psychological and social well-being of the Indian elderly. Funding for Section 608 of Title VI of the Comprehensive Older Americans Act should be provided to maintain basic services for Native American rural elderly, both on and off the reservation.

Legal Services

- Promote the research of current laws and unfair practices existing in the areas of inflated real estate taxes on rural property owned by the elderly, and excessive inheritance taxes on farm property, encouraging local rural organizations and senior advocacy groups to affect positive changes on these important issues.
- Establish county-wide legal service coordinators who would prepare and conduct legal needs and resource surveys; obtain needed information, resources, and assistance from members of the local Bar Association, the State Legislature, and other legal aide providers; provide educational training and information on legal service matters to outreach and paralegal workers, senior and other organizational meetings, and the news media.
- Continue and expand legal information and assistance under the Older Americans Act.

SPECIAL ORDER OF BUSINESS

- The definition of "RURAL," as used by the 1981 White House Conference on Aging in determining urban and rural delegate representation unfairly contributes to the perpetuation of an urban bias in aging services and programs. This definition, which considers all persons residing in towns with a population of 2,500 or more to be *urban*, grossly neglects the rural character of small towns with populations of between 2,500 and 50,000. Thus, the Rural Mini-Conference delegates recommend that the present WHCoA definition of "rural" be changed to that, as stated in the 1972 Rural Development Act, which considers all persons residing in areas with a population under 50,000 to indeed, be RURAL citizens.

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Through the 1981 White House Conference on Aging we witness the best form of American democracy. People . . . grassroots people, sharing in their government, and taking responsibility for shaping their own destinies.

This report on the Rural Mini-Conferences is an important part of that process . . . but we have only begun.

We are each instruments of change, but together, driven by dedication and conviction *we make a difference.*

Footnote: A conference questionnaire, developed in cooperation with Dr. Harold Cox, Chairman, and Gurmeet Sekhon of the Indiana State University Department of Sociology was administered to all Rural Mini-Conference participants. This questionnaire was tabulated by computer and analyzed, and provides significant demographic and attitudinal information, as well as a rating of rural needs. Copies of questionnaire results will be provided by National Green Thumb upon request.

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RURAL AMERICA:
COMING OF AGE
1981 WHITE HOUSE CONFERENCE ON AGING

Rural Mini-Conference Report

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February 15, 1981

the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on
Older Women

MCR-18

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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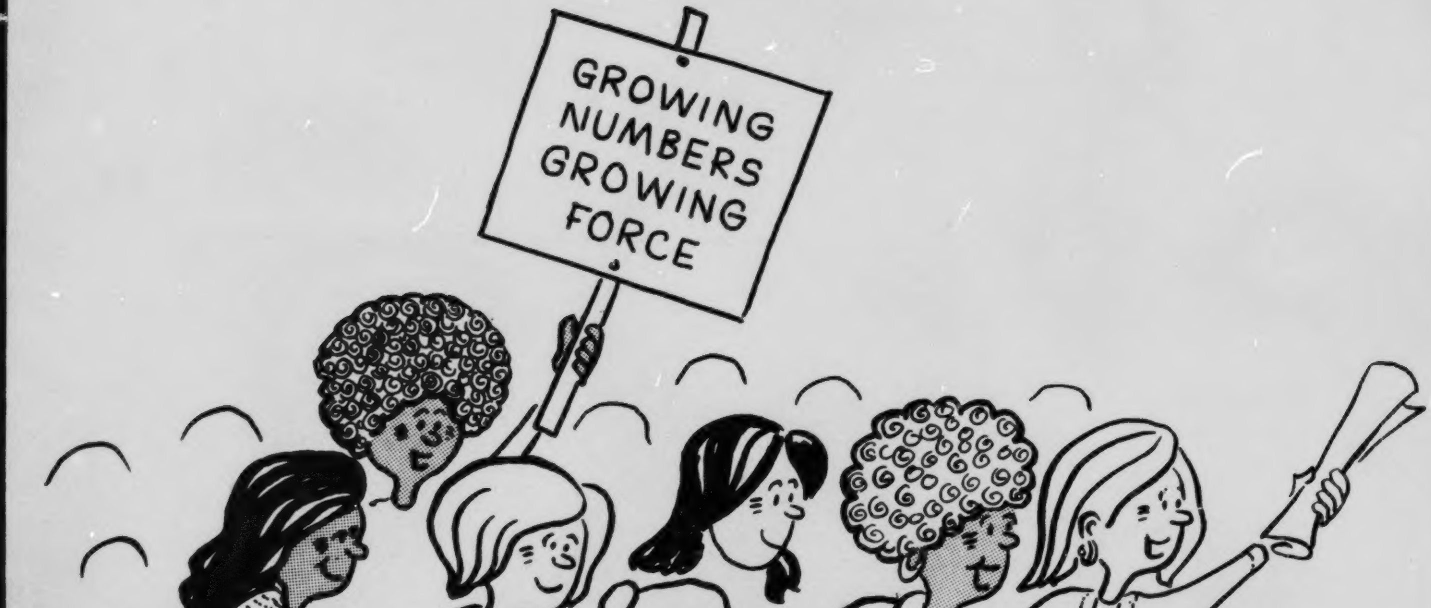
REPORT FROM THE WHITE HOUSE MINI-CONFERENCE ON OLDER WOMEN


GROWING
NUMBERS
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FORCE
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Convenors of the White House Mini-Conference on Older Women;

OLDER WOMEN'S LEAGUE EDUCATIONAL FUND

WESTERN GERONTOLOGICAL SOCIETY

The conference was made possible through a grant from the U.S. Administration on Aging with the assistance of the Women's Bureau, Dept. of Labor, ACTION, and International Paper Company Foundation.

Collaborating organizations were: The Congresswomen's Caucus, the National Council on the Aging, Women's Studies Program and Policy Center, George Washington University.

The White House Conference on Older Women was held in Des Moines, Iowa, October 9-10, 1980.

SOME STATISTICS TO PONDER

- *At age 65, women have an average of 18 years of life remaining.*
- *85% of surviving spouses are female.*
- *The average age of widowhood is 56.*
- *9 bridegrooms to every bride over 65.*
- *3/5 of all women over 65 are unmarried, while 3/4 of men are living with their spouses.*
- *2/3 of all widows live alone.*
- *1/3 of widows live below the official poverty line.*
- *Of women 66 and over, 91% are white, 9% Black, and 2% of Spanish origin.*
- *Almost half of women 75 and older live alone, compared to 21% of men.*
- *Women earn 59% of what men earn on the average.*
- *63% of aged Social Security beneficiaries are female.*
- *80% of retirement age women have no access to private pensions.*
- *1/2 of all employed women are in jobs without a pension plan.*
- *Less that 10% of widows receive pension survivor's benefits.*
- *Over age 75, there are twice as many women as men.*
- *Over 2/3 of nursing home residents are female.*
- *Women have an 8 year longer life expectancy than men.*
- *The number of elderly Black women has increased 26% since 1971.*
- *Among women 75 and older, 3 out of 4 paid more than 35% of cash income for housing.*
- *Women retire on less than half of what men do.*

and many more have not been gathered.

GROWING NUMBERS: GROWING FORCE

THE WHITE HOUSE MINI-CONFERENCE ON OLDER WOMEN

This was an historic conference for older women. We haven't come too far yet, but far enough to have the White House Conference on Aging planners recognize the need to look at the specific issues of older women. AND WE MADE THE MOST OF IT!

The most exciting part was the mix of people. They represented a cross section of older women in this country, younger advocates of older women's issues, and some men who are also interested in our welfare. It was the kind of mix that makes things happen.

What we all had in common was our concern about growing older female. The issues we discussed affected our guts because our own lives are at stake. We knew that if we don't speak out on these matters, they will remain invisible, and each older woman who confronts these problems will think she is all alone. We were determined to bring our concerns onto the agenda of the White House Conference on Aging, and into public consciousness. For we knew that if women's organizations and aging organizations combine their efforts, we can sway public opinion until these pressing wrongs are addressed.

ALL issues of aging are women's issues, because we represent a sizeable majority of the aging population. However, each of these issues impacts differently on women, and that is what we examined in this conference. Whatever the topic, we asked, how does it specifically affect middle-aged and older women? For example, are women affected at an earlier age than men? Are women's presumed roles part of the problem? Is dependency a factor? What special resources do women possess which should be brought to bear? How does women's greater longevity affect the situation? To what degree does sexism compound the problem?

Work sessions addressed fifteen topics, divided into three clusters. These were: INSURING ADEQUATE INCOME, HEALTH CONCERNS OF OLDER WOMEN, and QUALITY OF LIFE AND IMPACT OF AGING.

First, some questions and answers about older women. Then exerpts from the opening Speak Out and the session on Minority Women's concerns. Next, the essence of what was discussed in the Work Sessions, with a key proposal for each topic. Finally, the significance of the White House Mini-Conference on Older Women, the formation of the older Women's League to implement its program, and where we go from here.

QUESTIONS AND ANSWERS ON OLDER WOMEN

What is an older woman?

She's anyone who is willing to admit to it in this society which battles wrinkles and thinks of aging females as pitiful or comic. She is anyone who has experienced the combined impact of age and sex discrimination in the job market and thinks it is about time something is done about it. She's one of millions of middle-aged and elderly women, the fastest growing population segment in the country.

With resources shrinking, should we concern ourselves with the "middle-aged" population, male or female?

Because women traditionally are dependents, their life experience may be quite different from men. For example, a woman in her middle fifties, widowed after many years of child rearing and homemaking, is not eligible for any income security and is often left without health insurance and unable to buy adequate coverage. Homemakers don't have the cushions that other workers have if they lose their "job" by widowhood, divorce or desertion. For women especially, the middle years are crucial to avert a solitary old age in poverty.

But older men have problems too. Why focus on women?

Yes, men certainly do, and some of these affect the women they are close to. Men, on the average, don't live as long as women. Eighty-five percent of surviving spouses are female, which means much greater probability of widowhood, and very little chance of remarriage. But it's not a question of who has more problems. It's a matter of recognizing some of the differences in aging experienced by men and women, and adapting public policy to the special concerns of each.

Once you're really old, sex differences aren't so important. Why should the 1981 White House Conference on Aging examine the problems of women separately? After all, every aging problem is an older women's problem.

That's right, every aging problem is especially an older woman's problem. Why examine these questions from a woman's viewpoint? Because to find solutions, we must know the causes and then proceed to look for answers. The 1971 WHCoA did not address the problems of older women. It's about time! All of the major issues of old age are disproportionately those of aging women. The proportions go far beyond the statistical predominance of women in the later years. Poverty — women have lower retirement benefits, fewer pensions, less paid employment. A low economic status in the productive years is lowered further each year by inflation the longer one lives. Isolation — the widow hangs on to her independence and her home, but pays the price in loneliness. Nor is she likely to remarry. There are 9 bridegrooms to 1 bride over 65, despite the predominance of women in that age category. Crime against the elderly — the primary victims of con artists and muggers are little old ladies, chosen because they are vulnerable, easily intimidated or fooled (having been taken care of in the past). Institutionalization — why are women three to one the residents of nursing homes? Not just because they live longer, (men often become incapacitated before they die too), but because women are less likely to have someone at home to take care of them.

But we're already too fragmented. Shouldn't we just concentrate on those issues which cut across the board, like Social Security and health care, and housing which affects all older persons?

As a matter of fact, those issues have special impact on women. Take Social Security. Most of the proposed benefit cuts would be devastating, because women (especially the large number without mates) are so often dependent upon Social Security as their sole source of income. Any cuts in cost-of-living raises means less food, heat or medical care. In this difficult period, women are mobilizing in defense of their basic survival.

With government funds drying up, shouldn't we move away from categorical programs altogether and make age and sex differences irrelevant in public policy?

Let's not jump the gun. Until age discrimination is eliminated, protections such as the ADEA are necessary and compensatory programs to overcome the effects of age bias will be needed. Until women are on an economic par with men, special protections are a necessity. If dependents' benefits are eliminated or reduced (as some propose for Social Security) it will be older women, who are least able to carry the burden, who will suffer. Policies which appear on the surface to be sex neutral may really hit women much harder than men, because of the circumstances of their lives. The time for an age and sex irrelevant public policy will come when there is no [illegible]ism and sexism.

With changing sex roles and so many women going into the work place, won't the retirement problems of older women disappear in the next generation?

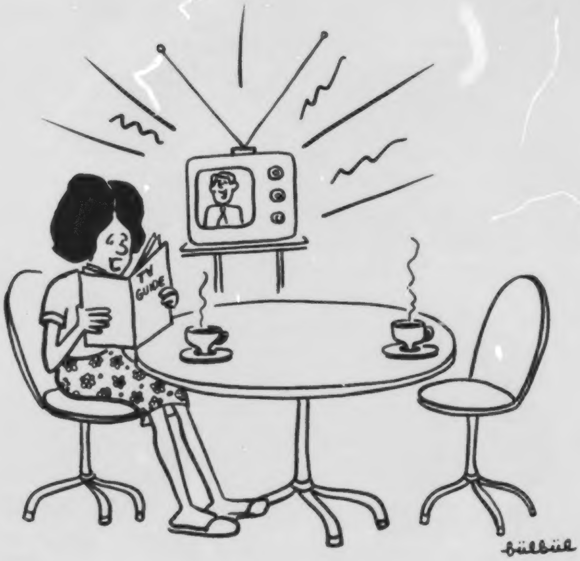
Not likely. It appears from the media that women have made great economic strides. While many more are moving into paid jobs than before, half of married women are still full-time homemakers. And although a few women are moving into management and non-traditional jobs, 80% still work in the "pink ghettos" of traditional women's work, with low pay and few benefits. The gap between the average male and female pay is widening, not getting smaller. As long as women move in and out of the workforce because of domestic responsibilities, even full job equality would not provide equal retirement income. Both Social Security and private pensions are geared to the work patterns of the average male worker. So there is little evidence that the retirement income crisis of older women will lessen for a long time to come.

Aren't women getting more than their share already? For example, Social Security pays out a lot more to women because they live longer and so receive benefits longer. Also, most aging programs serve predominantly women.

As far as women living longer, it costs more to be alive than to be dead. In the aggregate, women receive more aging benefits because there are more of them, but that's small consolation to the woman who's eking out a livelihood on minimum Social Security payments. SSI benefits are also going to women, three to one, because so many more women than men fall below the poverty line. The preponderance of women in aging programs should alert aging policy planners and gerontologists to examine the special concerns of women and to do something about them.

Since inflation is the number one enemy of all older persons, wouldn't adding any programs for underserved groups such as older women be inflationary and only add to the problems?

Inflation is of particular importance to older women. Unless indexed, real income is cut in half every seven years at an inflation rate of 10%. The average man faces two such halving periods after age 65, the older woman, three. But inflation cannot be controlled on the backs of the poorest and most vulnerable citizens. It is not "waste in government" to provide an adequate retirement income and necessary services to women who have given all their lives to their families and their communities.



Nonsense Mother! Why should you feel invisible?

KEYNOTE: SPEAK OUT OF OLDER WOMEN WHO ARE EXPERIENCING THE PROBLEMS (Exerpts)

Mattie Bigham, Dublin, GA: *I want all you women to just keep on pushing. Push! Push!*

Diane Spath, Glendale, AR: *I don't want anybody feeling sorry for me. I want to be my own person. I want to be looked up to and admired. I also want somebody to look up to and I have found them. I can look up to all of you. I'm proud of you and I"m proud of me, too. That's why I'm here.*

Gene Kingrea, Fairbanks, AK: *I didn't expect to be alone at past fifty. I didn't expect to have these things happen. None of us do. But if we can get outside help and internal help for ourselves and our own outlook, maybe we'll be able to do something about it.*

Eugenia Hickman, Berkeley, CA: *It seems that I'm working harder now than I ever worked before in paid employment. Not only that, but people feel free to call me at home with any problems they think I can help them with...not only older people but younger people who think they need the advice of some older person.*

Patricia Keller, Fayetteville, NC: *A man who serves the country for 20 years is eligible for retirement...But if he decides to marry that pretty young girl, he can divorce the wife who went with him all those years and she loses everything.*

Barbara Gilman, Little Rock AR: *If we gain a little on Social Security, we lose all our medical benefits, all our food stamps. That's a horrible way to run the means tested programs.*

Florence Brown, Healdsburg, CA: *We need to take this body and work together nationally for legislation. We've got to stand up and say we're tired of it.*

GENERAL SESSION: MINORITY CONCERNS OF OLDER WOMEN (Exerpts)

Any problem — housing, social services, income — will be three times worse for Black women. But the point is that if its a problem for Black women, it's a problem for white women too.

We call for a guaranteed income — a minimum way above the poverty line — that's a number one must for the 1981 White House Conference.

Mexican-American women are invisible. It's because there's no reason for them to be out of the house. My husband, I'll never divorce him. He deserves me. I am what he made me. "You're stupid. You're ugly. I'm the only one that would marry you." Physical is not the only kind of cruelty.

What is a dragon lady? The dragon lady is assertive, articulate, and effective.

There is much more detailed information on crops and livestock than on the conditions of farm women.

I am disabled from arthritis. I am exactly what this conference is all about.

INSURING ADEQUATE INCOME

To grow old without enough money to live in health and decency aggravates all problems of aging. By reducing options, poverty limits the control we have over our lives. It strips a person of dignity and reduces the quality of life. Women and minority men are heavily over-represented among the aged poor, so the most pressing problems of growing older female are economic, and directly related to the circumstances of women's lives. To a far greater extent than generally recognized, the income crisis of elderly women flows from dependency and from the wage differential between men's and women's work. Add to this the greater longevity of women. The older, the poorer.

At a time when older women are gearing up for action to combat their poverty in old age, government is pushing back, threatening the well-being of poor older persons more than ever. We have the double task of protecting benefits which currently exist, while tackling the underlying problems which make women so poor when they grow old.

Social Security

Retirement income of substantial numbers of older women consists of Social Security alone, so it is a precious commodity and must be protected while working for increased benefits. The average Social Security income for all aged women (1978 figures) was $2,537, compared to $3,390 for men — much too little to live on if it is the primary source of income. Although conceived as a supplement, Social Security has assumed the major role in retirement income for lower paid workers, of which women are the majority.

Lack of recognition of homemaking as an occupation is a prime culprit as far as women are concerned. The system is said to cover 90% of American workers, but the largest occupational class, homemakers, are still excluded from coverage for their work. A worker's benefit is computed on a basis of average wages over a 35 year period. The worker can eliminate only the five lowest years from this calculation, so that combining homemaking with paid employment will lower income as a result of these "zero earning" years.

Older women today are reaping the results of a lifetime of sex discrimination in the job market. Social Security checks reflect the wage differentials between the sexes, despite "weighting" in favor of the low-income worker. Until equity is achieved, dependents benefits must be protected, but they leave women vulnerable if they become disabled or are divorced. Caught between the built-in inequities of the system and proposed reductions of existing benefits, older women must choose their strategies carefully and build strong alliances.

Recognize the retirement income crisis affecting millions of elderly women. Defend current benefits while encouraging broad discussion on means to improve coverage for homemakers and low-paid workers. Taxpayer savings must not be made at the expense of poor elderly widows.

Pensions

The core of the problem is the misfit between women's work patterns and the pension system. Pensions reward the long-term, full-time, well-paid employee. But women are more likely to combine unpaid work in the home with part-time, sporadic, or poorly paid employment. The result: government and private pensions combined cover only 20% of retirement age women.

The "widow's blackout" is a provision in most pensions, whereby a worker who dies before early retirement age (usually 55) will leave no survivor's benefits, even if he worked many years under the plan, and fully intended his wife to receive pension income upon his death. This provision has devastated many older women. The "opt-out" privilege is another booby trap. Upon retirement a worker is permitted under most plans to decide against a survivor's pension for the spouse.

Pension discrimination follows a woman both in her roles as homemaker and employee. If marriage is a partnership, the person at home who cares for the family and raises children earns a pension as much as the partner with a pay check. At present, older divorced wives of government workers, railroad workers, and military wives are left stranded. Only foreign service wives have won some legislative protection.

Recognize marriage as a partnership in all pension law. Extend to divorced wives of government workers, railroad workers and military wives the entitlement to a pro-rata share of the pension, as recently accorded to foreign service wives.

Employment

Women over 40 are the fastest growing segment of the U.S. labor force today. 53% of women age 40 to 64 are either in the work force or looking for employment. But for most older women, the obstacles to obtaining satisfactory employment, and in many cases any job at all, are enormous. Displaced homemakers, recently divorced or widowed and without a husband's paycheck or pension to support them, must support themselves, but are rejected for "no recent job experience".

Eighty percent of all women work in sex-segregated, low paying, low benefit, low status jobs (clerical workers, service workers, sales persons). The percentage of older women in such traditional female employment is higher still, especially for minority women. The older woman returning to the job market from the role of homemaker has the additional obstacle of lack of recognition by employers of the skills gained from homemaking. With few exceptions, non-paid work is not considered work at all.

While age discrimination is illegal, it is rampant, combining with sex-discrimination to present double barriers for older women, and in the case of minority and handicapped women, triple barriers to job training and employment. Even aging programs discriminate against older persons, except in volunteer or the lowest paid positions.

In the long run, only a national full employment program will ensure jobs for all. Meanwhile, we demand a fair share of training programs and services designed specifically for older women. Build upon adequately funded displaced homemaker programs.

Means tested programs

Programs like Supplemental Security Income (SSI for the needy blind, disabled or over 65), Veterans Administration widow's benefits, food stamps, medicaid, general assistance, legal aid programs and subsidized housing, are the alternative for women when Social Security and pension systems fail them.

But it is estimated that well over half the women eligible for SSI never apply. Many are "new poor" to whom the procedures are bewildering, humiliating, and combine with the woman's own negative attitudes about accepting "charity" to discourage her application. Unrealistically low threshold levels of income and assets (the asset limit has not changed in years despite inflation) compound the problem. There is a moral double standard which expects the wealthy to plan their affairs around tax loopholes allowed by Congress, but frowns on poor people planning their modest affairs around welfare regulations permitted by the same Congress. Only the poor older person, usually a woman, is perceived as taking advantage of the taxpayer.

There is also a welfare gap for mid-life women. From the time the last child reaches 18 until she is eligible at 65 for SSI, the only means tested income available is disabled aid, blind aid, or general assistance, which is usually a pittance or nonexistant. The ages of 40 to 65 constitute a frightening, unprotected period of life for low income women or those who are suddenly divorced or widowed.

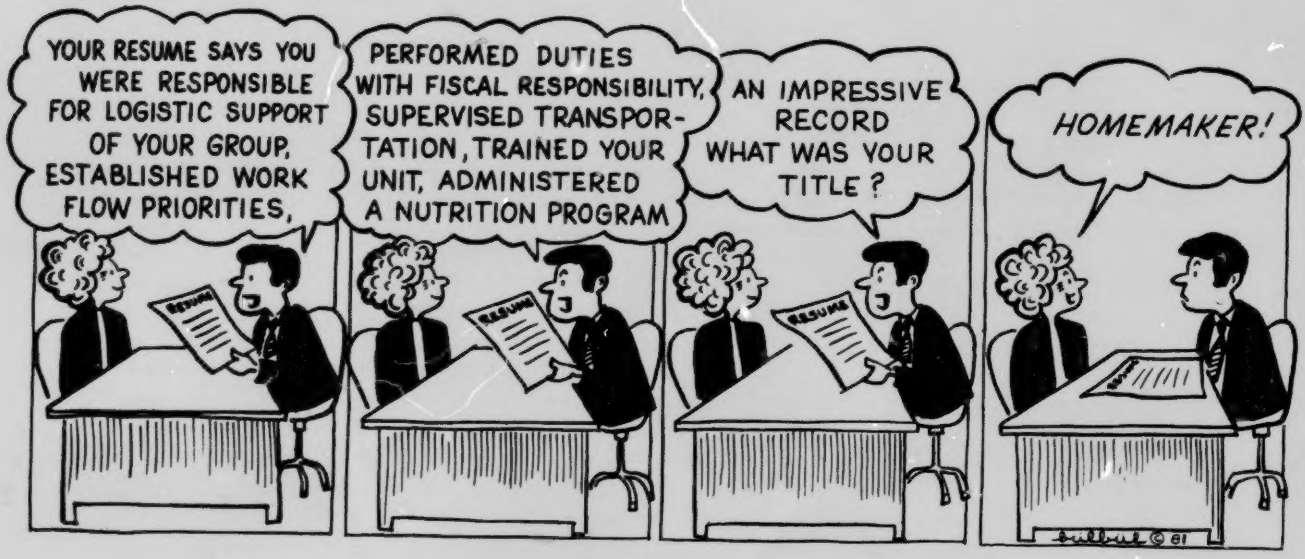
Remove the stigma of means tested programs and encourage all those eligible to apply. Resist shunting dependents out of Social Security entitlements into SSI.

Midlife planning

Since aging is not something most people look forward to, we tend to avoid planning ahead for the last third of our lives. Such preretirement planning as currently exists is primarily geared toward men or couples. Yet it is women who will have the longest and hardest road ahead, because it is we who will most likely end our lives without a mate and in poverty. We are the most frequent candidates for chronic debilitating disease and for nursing homes.

The middle years have been described as the adolescence of aging, and indeed there is much in common with these two periods of transition. But the first is seen as a period of growth and preparation for the future, while middle-age is viewed as an adjustment to loss. However, if regarded not as an end to productive years but as a new beginning, midlife planning could take on new meaning. A realistic view of both the dangers and the potential of growing older female is the starting place. Considering today's realities, not to plan ahead is dangerous except for the affluent minority, and even these women may be psychologically unprepared for being on their own.

Specialized educational programs need to be developed which approach midlife planning as gearing up for the last third of life, rather than winding down. Older women must take the leadership in designing such programs.


YOUR RESUME SAYS YOU WERE RESPONSIBLE FOR LOGISTIC SUPPORT OF YOUR GROUP, ESTABLISHED WORK FLOW PRIORITIES,
RESUME
PERFORMED DUTIES WITH FISCAL RESPONSIBILITY, SUPERVISED TRANSPORTATION, TRAINED YOUR UNIT, ADMINISTERED A NUTRITION PROGRAM
RESUME
AN IMPRESSIVE RECORD WHAT WAS YOUR TITLE?
RESUME
HOMEMAKER!
bulbul © 81

HEALTH CONCERNS OF OLDER WOMEN

For older women, health issues have double meaning. When chronic ills begin to strike, when sensory losses become more apparent, and when bodies are no longer as responsive as they once were, the personal stake in health issues becomes clearer. This in turn provides strong motivation for a turnaround in life style, diet and health habits, and for activism to improve health care for all. Secondly, older women are a reservoir of health care skills and are working (or want to work) in all health professions.

All five health topics considered at the conference recognized that older women have a vital stake and can make important contributions to turning the health professions around. Second, there are many myths about women and aging which affect our health and our health care. Good health is the profound desire of most persons as we grow old, for in a very basic sense, the underpinning of all happiness is health.

Cost and Delivery of Health Care.

Despite the size and strength of the "medical-pharmaceutical complex" there was strong consensus that our health depends upon our willingness to change this system. Certain themes emerged: (1) the special health problems of older women have been neglected or distorted; (2) there are gaps in care and insurance coverage between menopause and Medicare; (3) the health care system of the future will affect older women and will need our input; (4) we must fight for a fair share of what is now available while also working to broaden the base of health care delivery, especially for chronic illness; (5) and if we want to stay well, we will have to do a lot more for ourselves.

The medically dependent person may find herself virtually excluded when her status changes. A homemaker who is widowed or divorced, an unemployed person, or the younger dependent wife whose husband has retired, may lose coverage at a time when she is most vulnerable. Most conversion policies provide only a fraction of the benefits of the group plan at very high rates, or may not be available at all. An estimated 4 million women between the ages of 45 and 65 are without any health insurance.

Older women have been socialized to be entirely dependent upon "doctor's orders". However, when the patient and physician see themselves as partners, the quality of health care will be substantially improved. Also, women are the primary providers of health care in the home. With help, like Respite Care, they could do much more.

Health insurance coverage for uncovered women is the most immediate health issue faced by older women today. In the long run, a comprehensive national health program with emphasis upon preventive care, is the ultimate goal. Health care must be provided from cradle to grave — a right of citizenship.

Medical Research and Training

Medical research inevitably reflects the biases of those who pursue it. Selection of "important" questions echoes the attitudes and priorities of those persons (usually well-off, university educated, white males) who make the decisions. Problems of older women are not high on their list. On the contrary, myths and stereotypes about older women abound. The absence of research perpetuates and reinforces these myths. Older women themselves must break the cycle by demanding adequate research in areas of their particular concerns, and by enlisting the energies of more responsive women researchers.

Medical school curricula directly affects delivery of health care. For example, as long as menopause is seen as a deficiency disease or an endocrinological disorder, surgery (hysterectomy) or drugs (estrogens or tranquilizers) are reasonable remedies. But if seen as a turning point and as the beginning of a new stage in life rather than as an end, other kinds of therapies, such as exercise, diet, stress reduction, etc., might seem more appropriate.

Medical research should address ways of maintaining good health as well as treating disease. Proposals for self-help and mutual-help projects should include a research component if possible. NIA grants should be sought for this purpose. Longitudinal studies should include how women function best to keep themselves well. Minority women's concerns have been neglected in medical research. For example, the incidence of breast cancer among female migrant workers exposed to pesticides should be researched.

Older women must open the eyes of medical researchers and educators to neglected areas of concern. Combined sexism and ageism perpetuates myths which in turn affect the health care of older women.

Images of growing older female

For too long, older women have been "invisible", secondary, or perceived in dependent, passive roles without special strengths and attributes. Ideals of beauty are tied to youth, for women much more than for men. As child bearing and rearing come to an end, traditional roles provide few alternative functions and limited expectations. Women, raised and trained as care-givers, nurture and educate everyone but themselves. From the conventional viewpoint, a woman's work is done when the family is raised, although a third of her life may still be before her.

The first step may be to discover that an older woman's problem is not usually personal, but is social in nature and shared by many others. At a time of life when self-esteem is vital to move forward toward a new life, it may be at its ebb. For example, during painful divorces, bitterness and anger can sometimes serve only to immobilize women and to jeopardize their mental health. When a woman recognizes that she is not alone, she is usually on the way to improvement.

The media encourages or discourages stereotypes, confers status on people and suggests appropriate behavior. Advertising, especially, plays upon the fears of women of aging, because youth is so closely associated with beauty. Wrinkles, brown spots and white hair are presented as the end of the line.

Must we take control of our own lives and combat negative images of older women in the media and in public awareness? Most of us are in a better state of mental health than we think we are. Our problems usually are real ones which can best be addressed by mutual support and social action.

Long Term Care: Nursing Homes, Home Health and Continuum of Care

Over 70% of patients in nursing homes are women, and they are largely cared for by women. Likewise, persons receiving and giving care in the home are overwhelmingly female, and the same is true of adult day care facilities. Unpaid workers providing care to a spouse or a parent are also overwhelmingly women. Both patients and their caretakers are among the most oppressed segments of the population.

The reason so many women end up in institutions is because they are less likely to have a spouse to care for them. There is also a strong element of "out of sight, out of mind". An appropriate level of care based on the patient's needs and wishes (effective home care, group care facilities, board and care, shared living arrangements, etc.) could provide options to institutionalization. Unfortunately, reimbursement mechanisms, especially Medicare, are biased toward nursing homes.

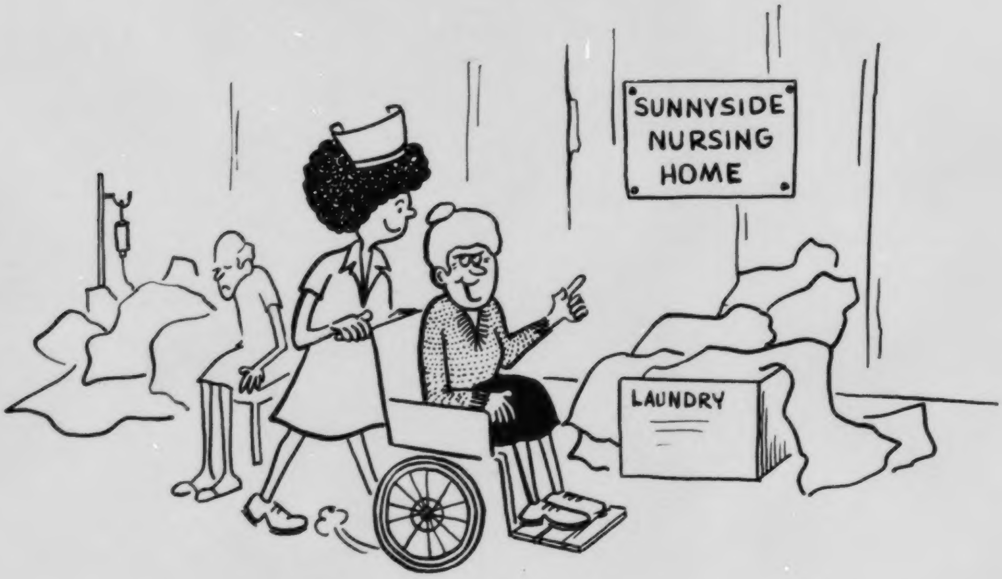
Upgrade the employment of primary care-givers in nursing homes and home health agencies. The term "custodial" care must be transformed into "Tender Loving Care". Turn the bias away from institutionalization toward a continuum of care based on the individual needs of the patient.

Alcohol and drug abuse

Little attention has been given to how gender and age combine to create special problems of alcohol and drug abuse. Yet middle-aged and older women are the major consumers of physician-prescribed drugs. While their patterns of alcohol consumption in later life may differ from men, alcoholism is a woman's problem too. Over half the adult women in this country have used prescription tranquilizers, stimulants or sleeping pills, and women account for one-third to one-half of the nation's estimated 10 million problem drinkers.

Myths and stereotypes perpetuate the situation. Male doctors over-prescribe tranquilizers because of their sexist and ageist biases. Drug companies reinforce stock negative images of older women The most prescribed drug in America today is Valium. An estimated 2 million women are addicted to this or other prescription drugs. The pharmaceutical companies spend more each year on advertising than on research, and a good part is directed toward pushing prescription drugs for older women. It is no wonder that doctors will advise a male patient to "work out" his problems in a gym or golf course, while a female patient with the identical symptoms is likely to get a prescription for Valium.

Combat over-prescription of drugs based on ageist and sexist conceptions of older women. Facilities and programs should be adapted to the older female alcoholic and drug abuser.



Take me to the meeting to discuss your pay and my living conditions and let's take over this joint!

THE QUALITY OF LIFE AND THE IMPACT OF AGING

Most older women who find themselves in a bind see their problems as personal misfortune, probably brought about by their own inadequacies. The common response is to try to make the best of things. Those whose consciousness is raised to an extent to recognize their plight as the product of injustice, rarely believe that the wrong can be put right. On top of very real inequities hangs this hopelessness that paralyzes action. Older women's low self-image, which every service provider must contend with, is a reflection of this sense of powerlessness.

But are we really so berefit of internal and external resources? We believe that we are not. A recurrent theme ran through the conference; "We are not helpless and something can be done about these problems, but we must take the lead". These topics, clustered under "the quality of life and the impact of aging", all emphasize the potential of older women to make a difference in our own lives and in those of others. Autonomy is essential to the quality of life as we grow old, so our involvement itself will affect a change.

The demographics of aging

The special concerns of older women have been largely obscured by the common practice of compiling statistics by age, sex, race, etc. but without cross-classification. Many of our needs have not been addressed because of our invisibility in research and policy making projects. When the aging are studied, women are rarely differentiated from men. When women are subjects of research, older and younger women are not considered separately. Significant differences in life expectancy, marital status, living arrangements, and income are determined primarily by sex, but these sex differences have not been adequately addressed in the field of aging. Review the statistics presented in the opening of this report, for example, and consider their implications for public policy.

Women over 65 attained adulthood in historical conditions considerably different than those which exist today, and these conditions contribute to the problems and inequities that older women now confront. The definition of women's "proper place" and the security of marriage have altered dramatically during the adulthood of this generation. Such factors set older women apart from their younger contemporaries and from men their own age.

Government data should be cross-tabulated by age, sex, race, marital status, income and geography. Aggregate data on aging should be collected in forms which bring older women out of invisibility.

The family in a state of flux

The family is not dead or dying, but it is in the process of change. Since the family has been the center of most women's lives, those changes can be crucial to our quality of life. There was consensus that the family needs to be redefined. A broadened definition from the American Home Economics Association was accepted. The family unit is:*two or more persons who share resources, goals, values and life-styles over time; a network of responsibilities and decision making which goes beyond blood, legal ties, adoption and marriage.* This definition would encourage the development of "families of choice" to perform those functions which families do best and help avoid isolation in old age.

The family can't do it all. There is a presumed partnership between the state and the family, but sometimes they seem to work at cross purposes. The more a family does to help its older members, the less the government feels obligation. When too much is expected of the spouse or daughter, such as prolonged care for chronic illness, the caregiver can "burn out" and the ill person can feel a burden by remaining alive. Institutionalization becomes the only avenue of escape for the caregiver, while the aged parent feels deserted.

The White House Conference on Aging should advocate the use of the expanded definition of the family in all public policy. Respite care programs are an urgent concern for all women.

Older women alone

Singleness exacerbates all the other problems. Differing mortality rates, and the tendancy of men to marry women younger than themselves, especially in second and third marriages, leave older women widowed. The result is that 85% of surviving spouses are female. The average age of widowhood is 56, which leaves one third of a life-span to go. Besides the vast number of elderly widows, there is a smaller but growing number of older women alone because of separation, divorce or desertion, in addition to those who never married.

To some women the end of marriage is tantamount to the end of meaninful life. To others, it provides an opportunity to develop in new directions. To keep one's autonomy is a fiercely defended goal for some whose greatest fear is dependency. The effect of "no-fault divorce" has been especially devastating to older women because it provides a green light to men to discard wives of many years, without the legal or social sanctions which provided some measure of protection for married women in the past. In cases where the wife has been replaced by a woman much younger, the sense of being discarded is particularly painful.

Advocate for uniform divorce laws which provide economic protection for the homemaking spouse. This is a priority issue for women's organizations.

Housing

Decent, safe, affordable housing is either non-existant or in such short supply that it creates competition among young and old, families and single persons. Many older women are institutionalized simply because they can't find housing. The greatest number of bank foreclosures are among women living alone. In one major city, 85% of the evictions were older women. The "bag lady", immortalized by Lily Tomlin, is becoming a more frequent sight on city streets. Far from being a comic figure, she is a stark reminder of the few options

CONCLUSION

The conference was neither a beginning nor an end, but an important milestone. Many of those who attended had worked for passage of displaced homemaker legislation or on other specific issues of older women. Some were activists in the women's movement, some were professionals in aging, a majority were women who personally had experienced the compounding effects of ageism and sexism. Apart from the objective issues considered and the recommendations which emerged, the conference expressed tremendous energy, enthusiasm and new hope born of common ground. As one participant stated, "There was a feeling that a lot of the problems are on the way to resolution...that it's not going to be this bad forever".

That spirit carried over to the organizing meeting of the OLDER WOMEN'S LEAGUE, which occured the following day. This newly formed grassroots organization vowed to work for implementation of the program developed at the conference, and to form chapters throughout the country. The primary purpose of OWL is to work for recognition of the concerns of older women and to develop the political clout to rectify some of the most pressing problems. In the words of Maggie Kuhn, who closed the meeting, "We have today been exhilerated, stumulated, empowered and NOW WE GO OUT, reinforced and fortified with new energy and belief in sisterhood, to do what we must do where we live and work...We have a vision, a great dream that is realizable! Our network of women will accomplish much because we do it together".

Some central themes which emerged in the final session of the conference were:

Women face poverty in old age because of dependency, wage differentials and greater longevity. The older, the poorer. Issues such as Social Security, pensions, employment opportunities, means tested programs are very much women's issues and need to be approached as such.

There are gaps in the present health care system. Women, organized and vocal, must address those gaps and move forward with other sectors for better health care for all.

Myths and stereotypes which have robbed us of dignity and self-esteem must be combated with vigor and with the positive role models of our own lives.

Passage of the Equal Rights Amendment is of concern to women of all ages.

Older women are "growing numbers; growing force" as expressed in the conference title. If organized, we can have considerable political clout. This new older women's movement will be a viable link between aging activism and the women's movement. In periods of retrenchment of entitlement and social services, this can be a significant development.

From now on, older women must be recognized as a specific constituency, which should be represented in planning, in implementation of program, and in public policy at all levels.

YOU WILL BE HEARING MORE FROM US!

for such women, and the spectre of what may lie ahead for many more.

Condominium conversions of former rental properties force out lower income women. They have great difficulty finding living accomodations they can afford, and frequently are forced to lower their living standard from poor to very poor. The upgrading of neighborhoods raises real estate values, uprooting older persons who have lived there for years. New concepts of living arrangements must emerge. Group and shared housing, homesteading, intergenerational housing and other alternatives need to be demonstrated and supported. We must challenge the ideology of independence.

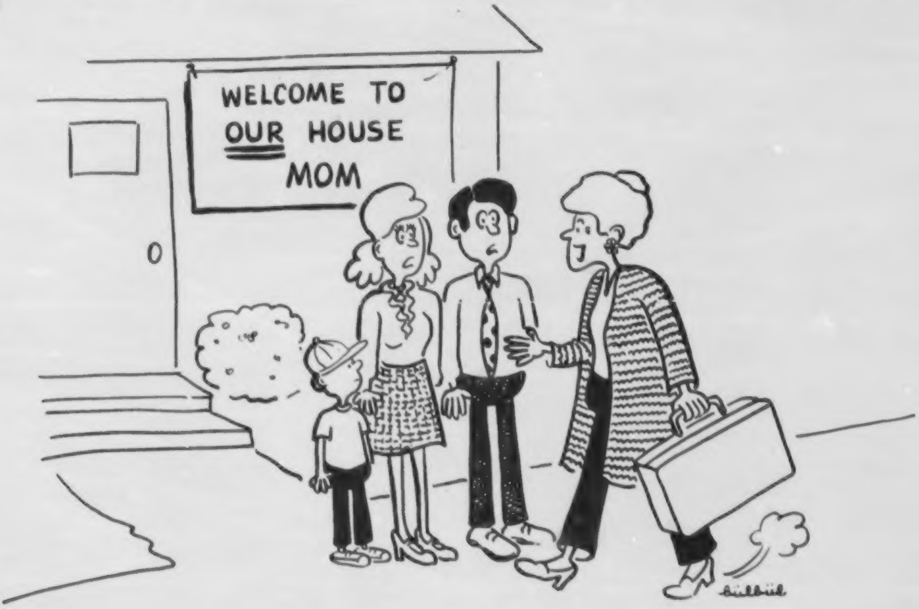
Support demonstration projects to provide housing alternatives, change zoning laws to make these feasible, and encourage "family of choice" households through public education and organizational efforts.

Older women as victims of violence and fear

The effects of crime against older women are as obvious as the bruises inflicted by a purse snatcher and as subtle as the lack of self-confidence after she realizes she has been the victim of a fradulent scheme. The crimes against older women range from the often reported robbery/mugging to the rarely talked about abuse by caretakers.

Fear of being attacked causes many older women to virtually imprison themselves within their homes. Quality of life is seriously impaired by this self-imposed house arrest. The pervasive fear of crime, especially at night, has a chilling effect upon the freedom of movement of older women. This is also the largest group of persons who do not report crimes, perhaps fearing reprisal. It is estimated that more than half the crimes against older women are not reported.

People must be made aware of the problem and its symptoms. Once out of the closet, citizen groups on the local level can utilize community supports and bring pressure to bear on law enforcement agencies.



Thanks anyway kids, but I've joined an older women's rent sharing coop.

A full report of the White House Conference on Older Women is available from:

The Older Women's League Educational Fund
3800 Harrison St., Oakland, CA 94611

and

Western Gerontological Society
785 Market St., Suite 1114, San Francisco, CA 94103

This printed report is 56 pages, and costs $3 per copy.

Other publications on older women from the two sponsoring organizations:

GENERATIONS, Journal of the Western Gerontological Society. August, 1980 issue: Women and Aging.

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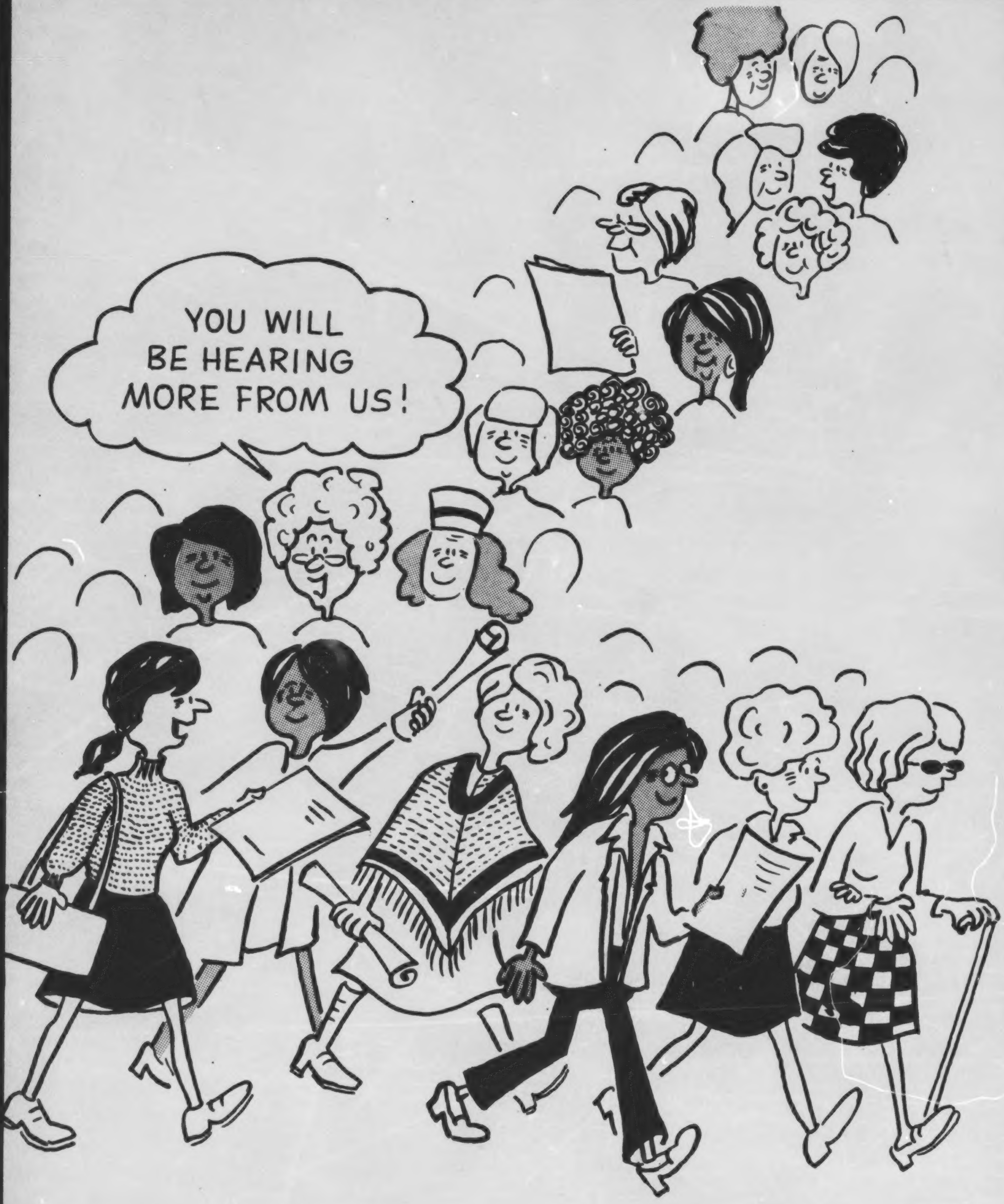
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the 1981
White House
Conference
on
Aging

Report of the Mini-Conference on Spiritual and Ethical Value System Concerns

MCR-19

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

the
White House
Conference
on
Aging

REPORT
of an
OFFICIAL MINI-CONFERENCE

Convened By
THE NATIONAL INTERFAITH COALITION ON AGING

National Symposium:

Spiritual and Ethical Value System Concerns

Erlanger, Kentucky - October 27-30, 1980

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SPIRITUAL AND ETHICAL VALUE SYSTEM CONCERNS
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PREAMBLE

Aging in the United States takes place in a society so pluralistic, fragmented, specialized, bureaucratized, and secularized that matters of the spirit--the moving and integrating force in life and personhood--are largely ignored. The result is that aging, which should and could be crowned with integrity, acceptance, wisdom, and fulfillment, is too often characterized by aimlessness, loneliness, hopelessness, and despair. To change this condition, wholistic well-being, inclusive of spiritual well-being and its associated values of human dignity and freedom, should be the chief unifying goal of all social action, public and private, that is directed toward the aging.

A wholistic view of the individual sees him or her as a functioning being, coordinating vitally the physical, emotional, intellectual, spiritual, and social dimensions of life as an inextricable totality. Change in one dimension affects the whole. Neglect of one dimension diminishes all. Such a view of the individual requires a resonance of the social order to organize its functions, processes, and services in support of wholeness.

The term "spiritual" is not considered as exclusively a dimension of religious life and religious practice. The spiritual pertains "to a person's inner resources, especially one's ultimate concern, the basic value around which all other values are focused, the central philosophy of life--whether religious, anti-religious, or non-religious--which guides a person's conduct, the supernatural and non-material dimensions of human nature. We shall assume, therefore, that all (persons) are 'spiritual,' even if they have no use for religious institutions and practice no personal pieties..." (Moberg, 1971, 3).

In the light of these considerations, the following principles of spiritual/ethical concern in aging emerge:

Human Dignity

The primacy of human dignity persists throughout life, despite our dependency and vulnerability. Because of the spiritual recognition that we are all vulnerable and dependent before God, an age-integrated community is the basis for our life together.

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Spiritual Well-being

Worldly needs--economic, physical, social--must be met but are not sufficient in defining quality of life. Spiritual well-being of all people is a distinct and fundamental need.

Service

Since there is value in caring and coping, rather than just curing, our ethical concern must insist on all these priorities being operative in health and social services to and with the aging.

Symbolic Meaning

The symbolic and ritual meanings of acts are as important as their utilitarian outcomes. The symbolic meaning of how we treat older people has a public meaning for all of us.

The Value of Hope

In aging, death and tragedy are part of reality we cannot deny. Neither represents final defeat if we affirm the value of hope.

Ethical Witnessing

Compassion and justice have priority over efficiency and legality. One task of the faith community is to urge all of us to bear ethical witness to this priority in aging.

OVERVIEW

White House Conferences have several functions, the most important of which is effecting or stimulating change in societal attitudes, changes in values and ethical considerations, changes in social structure and intergroup and intergenerational relationships, changes in functions of institutions, agencies, and organizations, and changes in the purpose of life and well-being (Tibbetts, 1980).

A National Symposium on Spiritual and Ethical Value System Concerns in the 1981 White House Conference on Aging was held October 27-30, 1980, near Cincinnati; convenor of this official mini-WHCOA was the National Interfaith Coalition on Aging (NICA). NICA is comprised of 32 organizations and agencies of Protestant, Roman Catholic, and Jewish faiths and of several national secular organizations in aging.

Approximately 50 national leaders and experts from the fields of religion, ethics, sociology, history, philosophy, law, and medicine were invited to participate in the mini-conference. This report reflects their consensus.

Specific policy recommendations from the working groups of the mini-White House Conference on Spiritual and Ethical Value System Concerns are included under the following seven issues:

1. Spiritual well-being of older Americans
2. Universal ethics for an aging society
3. The role of religious institutions in an aging society
4. Church/state relationship in an aging society
5. Attitudes of society toward aging
6. Contribution of the older person to American society
7. Age vs. need as a basis for national policy

Examples of projected actions are offered for each policy recommendation. White House Conference on Aging (WHCOA) delegates are urged to expand upon these starter-lists of actions which would enhance the spiritual and ethical posture of national policy.

POLICY RECOMMENDATIONS

1. Spiritual Well-being of Older Americans

- Issue

The neglect of the spiritual as a component of personhood impairs the physical and psychological well-being of the older adult and, as a consequence, the well-being of society. Interpretation of the constitutional protection of religious faith and practice often leads to its elimination in planning, provision of resources, and evaluation of tax-supported programs for the elderly. Furthermore, diversity of views regarding spiritual nature must not be used as an excuse. Policy can be nonsectarian without being antisectarian as spiritual and religious values are properly exercised within a free secular society.

- Spiritual and Ethical Principles

Regardless of outward religious belief or practice, human nature is not whole unless all dimensions of human experience and existence are nourished. The spiritual infuses and links the material and relational aspects of life.

- **Policy Recommendations**

National policy on aging must not only recognize and permit but, in many cases, provide resources for the satisfying of all real needs of older persons, including spiritual nurture. Policies must incorporate the spiritual dimension in the training of professionals and nonprofessionals in aging and in the planning, implementing, and evaluating of programs, facilities, and resources aimed toward the older American.

- Examples of Projected Actions

a. Research in the quality of life, health, and life satisfaction should include spiritual components. A range of other research possibilities are identified by Moberg (1980, 42-43) and Cook (1976, 95-98), including the effect on aging persons of a belief in religion or an absence of belief; religion and policy; and religion and gerontophobia.

b. Funding under the Older Americans Act should continue to support such training efforts as Project-GIST/Gerontology in Seminary Training (Cook, McGinty & Ziegler, 1980) and, further, should build upon the successful methodology and in-place network of training centers within the religious sector.

c. Model or pilot programs should be designed to implement wholistic well-being approaches; these must also be tested for replication. Particular benefits would accrue where cooperation between congregational volunteer services and area agencies network services could be coordinated.

d. The above examples of research, education, and model programs should not be omitted from federally legislated resources. Opportunities for involvement by nonsectarian collective efforts nationally should be encouraged to assist federal and state governments in the improvement of the total well-being of older adults.

2. Universal Ethics for an Aging Society

- Issue

The pluralistic nature of world society has led to the common viewpoint that there are few, if any, ethical precepts, and that values are largely relativistic. Consequently, national policy in aging has been formulated without sufficient consideration for the core ethical values that apply to all people of all ages. Among these are duty, service, sacrifice, love and compassion, reverence for human life, social justice, and respect for the autonomy and individual difference of people.

- Spiritual and Ethical Principles

All societies have ethical values that are recognized as commonly applicable to the population. To ignore those values in developing policy is to deny their existence and significance to the detriment of older people.

- **Policy Recommendations**

Reports of the delegates to the 1981 WHCOA should include a section that addresses the ethical bases of policy recommendations.

In matters affecting older persons, policymakers should identify and include in any legislation and regulations the relevant ethical values and their implications.

- Examples of Projected Actions

a. The WHCOA should recommend ways to strengthen the Social Security system quickly. Citizens have the right to count on government to live up to its promises that benefits will be there on retirement. At the same time, workers must not be expected to carry an unrealistic financial responsibility. Social Security underpins and strengthens our entire society; therefore, all of society should share in its financial support.

Delegates should consider equitable adjustments in distributing benefits in view of whole categories of people whose members do not live long enough to satisfy actuarial indices of life expectancy.

b. Incentives for the use of and availability of Medicare and Medicaid need serious examination in the light of the desirability of universal health care. Such incentives ought to promote wellness and health rather than make illness economically profitable.

c. Assignment and distribution of benefits should maintain the dignity of the human being. In all services, the operative ethical concerns should be accessibility, confidentiality, anonymity, and respect for individual choice. Eligibility requirements should not require either impoverishment or dependency.

d. Reimbursement should be provided for long term care, whether within an institution or within a person's home, so as to foster individual human dignity, quality of life, and prevention of premature and/or inappropriate placement. Included should be reimbursement of nonskilled personnel caring for the terminally ill whether in the person's home, a home for the aged, or a hospice.

Religious sponsorship of retirement facilities should not only be encouraged but should be extended. Recent attempts to shift liability of local sponsorship to regional, state, and national denominational levels require that federal and state governments reexamine tort laws and legal suits against retirement homes and long-term facilities.

e. The federal government should give high-priority to research in preventive medicine. Keep-well health assessment clinics for noninstitutionalized elderly should be made available through government and private assistance and should incorporate principles of wholistic well-being.

f. Public and private sectors along with religious bodies should cooperate in further development of the hospice movement to deal with dying and death on a basis of intrinsic human worth rather than simply on a level of limitations: pain, illness, uselessness, and senility.

g. WHCOA policy recommendations for allocation of resources should be based on justice and compassion, providing for those who are no longer a part of the work force whether because of age or frailty. Changes in benefit programs tied to cost-of-living indices should not favor one group over another.

h. Government, private, and religious sectors are called on to share in a commitment to the aged individual by working cooperatively to advance affirmative action programs at all levels of society for the purpose of combating ageism, racism, and sexism.

i. As a matter of social justice, the government is called on to give focused attention to the critical needs of the aging members of minority groups and to the special needs of older women.

j. To rectify an imbalance in availability of resources, the government and the religious sector should both work to develop models for meeting the specialized needs of rural aging persons; these needs derive from such factors as isolation, distance from services, and transportation limitations.

3. The Role of Religious Institutions in an Aging Society

- Issue

Although the religious sector is the most massive voluntary grouping in the United States, its potential in that capacity is neither sufficiently recognized nor adequately utilized. For example, the government often creates agencies to do what religious groups, based on their unique nature, could be negotiated with to do as well or better. This duplication is a wasteful drain on society, financially and otherwise.

- Spiritual and Ethical Principles

Religious institutions are uniquely equipped to provide a support community that can be offered by no other grouping in society. Churches and synagogues can act toward the family and individuals as the family acts toward the individual in offering care and concern. These resources are particularly important for older persons, who may be lonely, who may be without family or other meaningful relationships, and who may lack a sense of worth.

- **Policy Recommendations**

The 1981 WHCOA must consciously recognize and articulate the religious sector's extensive resources for dealing with the problems of aging; by its very nature, religion includes a concern for aging among its priorities. Delegates are also encouraged to define avenues of dialogue between governmental and religious bodies in order to tap those resources and avoid expensive duplication of effort.

- Examples of Projected Actions

a. Because our increasingly aging society affects all sectors, more public funding should be assigned to religious agencies to deal with the following concerns of the elderly: isolation occurring from loss of spouse or family or home community; counseling to deal with loss of self-esteem accompanying retirement or loss of productive skills; faith support to cope with fears surrounding loss of health and impending death.

b. The government, working through organizations such as NICA, should publish a list of services offered by various religious organizations. Guidelines should be included which suggest how church, state, and family can cooperate in obtaining necessary services for individuals.

c. Various types of educational institutions should be requested to incorporate models of collaboration between church and government into their curricula. Continuing revision of the models is important.

4. Church/State Relationship in an Aging Society

- Issue

In recent decades the interpretation of church/state relationships has become increasingly unclear. One result has been an unsatisfactory distribution of tax-supported programs intended to benefit the elderly. Fear of constitutional violation of church/state separation has led to the discouragement or prevention of religious bodies from doing potentially important roles in providing care and nurturing programs for the elderly.

- Spiritual and Ethical Principles

We strongly affirm the constitutional formula for separation of church and state: the official functions of the state must not be interlocked with the official or institutional functions of any church. These two entities must be kept separate. Such separation, however, as provided for in the constitution, leaves room for moral, spiritual, political, and administrative interaction and for responsive teamwork.

- **Policy Recommendation**

Government guidelines for publicly funded programs must be reexamined to adhere to constitutional provisions. Religious bodies must not be discriminated against through an exaggerated concern for or an eccentric definition of separation which excludes any relationships or sense of working together in common purpose.

- Examples of Projected Actions

a. Churches and synagogues should be among those agencies allowed to administer tax-funded projects for the elderly. Religious groups will thus become more productive in their natural roles as care providers.

b. Spiritual care (clergy visits, for example) should neither be denied to nor forced on elderly residents of publicly funded institutions. To deny such care is to distort separation of church and state.

c. Government should sponsor study and dialogue to clarify definitions of religious institutions, as well as criteria for judging actions which would not violate constitutional strictures against "establishment of religion."

d. Similar study and dialogue is needed to clarify the relative roles of the state, health care professionals, religious and private sectors in dealing with the complex and critical issues surrounding dying and death.

e. Tax funds should be provided for the education of professionals, including religious professionals, in the fields of gerontology and geriatrics.

f. Pilot programs should be initiated for the use of tax-funded transportation systems for aging people to attend secular functions held in religious facilities. If the results are favorable, such programs should be expanded to the maximum feasible extent.

5. Attitudes of Society Toward Aging

- Issue

American society places a heavy emphasis on youth as a virtue in itself. Consequently, there has been an increase in ageism (discrimination against older people as a group based on nothing other than their age).

- Spiritual and Ethical Principles

All points on the age continuum are equally endowed with meaning and with the inherent right to respect from those at other points on the continuum.

- **Policy Recommendations**

Government, religious, educational, business, and social agencies have a responsibility to promote an attitude that no one age level is more valuable than any other. Two steps are most crucial:
a) in all phases of education, the process of aging must be correctly stated and positively presented for all age levels;
b) media must reform the tendency to suggest that there is necessarily competition between the elderly and the young to obtain life's necessities and luxuries.

- Examples of Projected Actions

a. Educators and other professionals concerned with the well-being of older people should advocate a philosophy of lifespan development and lifelong learning. Change in curriculum and training of teachers and administrators should reflect recognition of aging and lifespan development.

b. Mass media should eliminate negative age stereotypes. Advocacy groups such as the Gray Panther Media Watch could monitor such efforts. Positive images presented through the media should, at the very least, show older people acting constructively in the mainstream of society, not restricted to their own groups or separate activities.

c. Religious bodies should accept a responsibility to present positive images of aging and to communicate them through all means at their disposal.

6. Contribution of the Older Person to American Society

- Issue

During the past few years our society has emphasized its responsibility to older adults. However, not enough has been said or done about the responsibility of aging persons to society.

Ways must be found to use the skills, abilities, and experience of older adults for the benefit of families and society in general. The aging must be empowered in some way to have a larger influence and voice in determining policies, programs, and legislation affecting their own well-being.

- Spiritual and Ethical Principles

Symposium participants affirmed the ethical imperative of society to recognize the abilities and potential of the elderly and the reciprocal obligation of the elderly to make their wisdom, expertise, and influence available to society.

Education for older people has importance for their own coping, giving, and growing. Older adults can participate as teacher and learner in continuing education. Both roles benefit society by keeping the elderly's knowledge, skills, and economic know-how engaged. Growing--that is, personal and spiritual growth until the end of life--has a validity of its own and deserves support from our social and educational institutions.

Human dignity and the intrinsic value of individuals are the bases upon which the elderly may discern that they can take greater responsibility for their own lives. The aging must take a leadership role in the struggle for their own liberation.

- **Policy Recommendations**

The WHCOA should call for government, social, and religious agencies to cooperate in finding specific ways to: a) utilize the skills, abilities, and experience of older adults for the good of society and b) train, empower, and encourage older adults to assume leadership in social, legislative, and religious matters and in determining needed services for the aging.

- Examples of Projected Actions

a. The government should reexamine the effect of tax rates on income earned by those who choose to keep working in the later years.

b. In the light of the act lifting mandatory retirement from government and military jobs, religious, educational, and other exempted employers have an obligation to reexamine their own policies.

c. Educational institutions should: 1) provide learning opportunities for older people at times and places accessible to them; 2) provide opportunities for retraining, career changes, and adaptation to life situations; and 3) make the fullest possible use of older people as resources for the education of the young and of one another.

d. Professional schools should reorient training to include a new definition of the task at hand: empowering the elderly and helping them to do for themselves more of what the professionals now do for them.

e. Media have the responsibility to present images of the elderly as contributors to family and society.

7. Age vs. Need as a Basis for National Policy

- Issue

Initial structuring of WHCOA Technical Committees placed a heavy focus on "creating an age-integrated society," suggesting that delegates should favor need-entitlement over age-entitlement. The desirability of this attitude, however, should not automatically be assumed. In considering future allocation of limited national resources, it is inappropriate to single out either age or need as a sole basis for national policy.

- Spiritual and Ethical Principles

Ageism and gerontophobia, both violations of the value of persons, are more prevalent in America's youth-oriented culture than are commitments to age-irrelevancy. Change in societal attitude is a necessary condition for an equitable policy of need-entitlement.

Both an age-irrelevant society and an intergenerational society (two meanings of age-integrated) seem desirable in certain situations, but neither is a complete good when considered exclusively. Further, age-integration in itself should not automatically be assumed to be either good or bad. It is desirable to raise the issue, but it must not be assumed without evidence that age-integration is the desired change, or even the prime issue under all circumstances.

- **Policy Recommendation**

All those responsible for making policy or program decisions should appraise carefully the age vs. need bases, seeking to proceed slowly and deliberately toward a combination of these approaches. The basis should be decided with attention to the particular group of aging persons and to the particular policy area being considered at any given time.

- Examples of Projected Actions

a. WHCOA delegates should avoid locking all policy recommendations either to age-entitlement or need-entitlement.

b. After the WHCOA, the federal government should lead the way in research on the pros and cons of age vs. need, inviting critiques from other major sectors of society concerning a workable policy mix.

c. Public and private sectors should collaborate on a massive educational effort aimed at the eradication of ageism and gerontophobia in American society. They should lift up accurate and positive images of aging, ultimately making possible a realistic consideration of need-entitlement as a basis for policy.

PERSPECTIVES ON RECOMMENDATIONS

As the mini-conference on spiritual and ethical values looked at the challenge of wholistic well-being, which includes spiritual dimensions of life, and at an ethical base for decisions, the preceeding recommendations emerged. The overall emphases of "wholistic well-being" and "pluralism" were maintained.

Wholistic Well-being

In line with a wholistic approach, the importance and priority of caring for the spiritual well-being of older people cannot be overemphasized. The concept of spiritual well-being recognizes the divine and communal covenant reaching across many generations; spiritual well-being also plays a part in the qualitative reality of life at any age. Attending to spiritual well-being means meeting the needs of older people as individuals living in a social context of generations.

Pluralism

One obstacle to simple answers for the problems of aging is found in the nation's pluralism. Since our society has broad, overlapping, and contradictory values sets, it is difficult to articulate the beliefs and shape the norms we hope our policies will reflect. Current political realities, economic forces, and vested interests may induce some of us to propose new measures and others among us to defend old ones without paying serious attention to their philosophical implications. Especially in the policy arena, one can trace how legislators sought to balance demands advanced by different groups that advocated radically divergent lines of action. Policy outcomes, consequently, embody the layers of compromises inherent in a dualistic, pluralistic values system (Achenbaum, 1980,1;11).

Symposium participants considered rationales for the preceding recommendations as represented in the following perspectives from comprehensive materials (see references).

1. Spiritual Well-being of Older Americans

National attention was given to the spiritual needs of older adults during the 1971 White House Conference on Aging through a special issue section on spiritual well-being. This section produced both a background paper (Moberg, 1971) and a set of recommendations for action. Bringing to fruition the spiritual concerns of the 1961 WHCOA, this 1971 section identified a) that the idea of spiritual well-being is not solely or specifically within the domain of the religious sector; b) that spiritual well-being is an issue for valid national policy action and resources; and c) that spiritual care, such as pastoral services, meets a legitimate human need and, thus, should be a reimbursable service in institutional and community intervention services, both in public and private applications (Policy Recommendations, pp. 57-60).

Spiritual values differ among individuals and societal institutions. The National Interfaith Coalition on Aging (1975) adopted a short definition of spiritual well-being: "the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness." While stated in religious language, this definition indicates the all-encompassing nature of the spiritual, however it is interpreted, and suggests a lack of wholeness when it is absent.

Problems of definition and evaluation, however, do not nullify the need to address spiritual well-being in programs and policies legislated for older Americans. While research continues in this field, direct action should be taken to assure that spiritual well-being needs of older adults are met.

Definitions of wholistic well-being, as well as of its physical, material, social, psychological, spiritual, and other components, are normative. The norms of a dynamic, pluralistic society are constantly changing, as divergent political ideologies, ethical systems, and religious perspectives engage in the struggle to shape the future of society. There is an urgency to move toward total human well-being as a central goal according to which opinion leaders policymakers, administrators, professionals, and citizens of all ages might seek a common and human policy (Moberg, 1980,41).

2. Universal Ethics for an Aging Society

The religious sector is not the sole value-setting agent in our society. Established customs, cultural mores, civil laws, interpretation of constitutional law, and expediency also contribute to a spectrum of values.

The "core moral precepts" (Moberg, 1980,15-16) of both secular and religious civilizations, past and present, have been very similar to each other and can readily provide an ethical basis for contemporary society. For instance, C. S. Lewis (1947,56-64) identified eight objective values which were held in common by the fourteen civilizations which he studied (Ancient Egyptian, Old Norse, Ancient Jewish, Babylonian, North American Indian, Hindu, Ancient Chinese, Roman, Christian, Greek, Australian Aboriginal, Anglo-Saxon, Stoic, and Ancient Indian). Lewis studied original philosophical and religious/ethical statements and summarized them under the following headings:

- The Law of General Beneficience (active goodness or kindness)
- The Law of Special Beneficience (active goodness or kindness)
- Duties to Parents, Elders, Ancestors
- Duties to Children and Posterity
- The Law of Justice
- The Law of Good Faith and Veracity
- The Law of Good Mercy
- The Law of Magnanimity

According to Lewis, these eight objective values could and should be used dogmatically as criteria for making rules (policies) which avoid tyranny and permit obedience that bars slavery.

These universal value principles apply to all people of all ages and apparently are consistent with all of the leading ethical-religious systems. Also, the implied values of duty, service, and sacrifice have clear and significant applications to geri-ethics and in intergenerational relationships. They also reflect, affirm, and solidify in a nonsectarian frame of reference the central values of the Judeo-Christian heritage in American society. Dyck (1980) believes that care of the whole person requires consideration of an additional three basic Judeo-Christian concepts:

"compassion, which affirms our respect for all human beings as persons having worth in themselves; ...covenant, which affirms our respect for human beings as persons having worth in relation to us and to others; ...and community, which affirms human beings as persons worthy in relation to the whole moral universe in all of its power and reality." (p.45)

3. The Role of Religious Institutions in an Aging Society

Church, synagogue, and other religious organizations serve both religious and social functions in American society. While the social aspects of organized religion may be integral to beliefs and spiritual motivations, many social expressions appear in the form of human services offered in a manner to enhance human dignity, promote individual wholeness, and meet basic human needs. In the days before governmental health and welfare programs emerged, the poor, sick, dispossessed, orphaned, widowed, and dying were traditionally and historically served by church and synagogue. Today, the religious sector remains a key provider of services and programs vital to meeting needs of the elderly. These extend to housing, health care, self-enablement, transportation, counseling, life enrichment, nutrition, and volunteer service opportunities, as well as support in situations that involve bereavement or one's own impending death.

One of the chief architects of societal values, the religious sector has the opportunity and the obligation to translate, reinforce, and articulate spiritual beliefs in terms commonly understood. These terms are crucial to the inclusion of ethical values in national policies. Religious institutions, as upholders of moral values and as advocates for the elderly, possess awesome potential for activating change. For instance, a rich opportunity exists in the area of civil rights. According to Dr. Arthur Flemming (1980), "much depends on the commitment of our people to Judeo-Christian values. 'Thou shalt love thy neighbor as thyself' is a commandment that places upon us a common responsibility to never pass up an opportunity to help our neighbor achieve his or her highest possibilities. ...This is the only way we can develop public opinion that will offset opposition to implementation of laws dealing with racism, sexism, and ageism."

Congregations represent a continuing opportunity for interaction between generations. Although some congregations operate within highly age-graded, sex-segregated programs, the church and synagogue still reflect one of the best models of what we might look for in an age-integrated society.

4. Church/State Relationship in an Aging Society

Guarantees under the First Amendment of the U.S. Constitution include freedom of religion, the extension of which is the separation of the functions of church and state. Within this formulation, however, religious groups enjoy rights and privileges which assure the free exercise of faith and practice. They may engage in any business, own property, operate schools and charitable agencies, and freely and publicly teach and express viewpoints. Further, they may contract with public or private entities to provide services and assist the government or private sector in meeting special needs and accomplishing desired ends.

Our society needs a better understanding of the roles and relationships between government and religious bodies and more cooperation in planning and implementing policy and programs. Coordination of efforts could be assisted by agencies such as the National Interfaith Coalition on Aging (NICA), which includes official representation from Roman Catholic, Jewish, and Protestant denominations and from secular national organizations dealing with aging.

The symposium raised a number of questions and identified areas in which legal and ethical issues come to bear on policies and programs relating to older people: in the responses of churches to government-declared social problems; and when churches participate in programs for the aging which are funded in whole or in part by public funds, raising possible first amendment considerations (Baker, 1980,3).

Questions of the immunity or liability of sponsoring groups and parent religious bodies could threaten the basis upon which many services have historically been available and flourished. Examples include cases where the care of the elderly is involved or where malpractice is charged in matters such as pastoral care (p.6).

Programs for the aging may be properly operated using public resources without offending the principle of separation of church and state even if the reason for such activity is religious, as long as the primary purpose of such activity is not religious. (p.9)

5. Attitudes of Society Toward Aging

One of the most serious ethical problems confronting our nation is ageism. It is likely that the attitudinal base of ageism is gerontophobia (Bunzel, 1971,1972), the fear of one's own aging and death. Its presence has been manifested in most of the helping professions, and its sources can be traced to many aspects of the life experiences of people who have been and continue to be socialized in America, including many who have decision-making roles in relation to national policy for aging (Moberg, 1980,29-30).

In our society the attributes of youth are valued over the attributes of advanced age. Yet, as Rabbi Siegel (1980) points out: "By disdaining the old we are in a sense saying we cannot learn from the past, we must start all over again in formulating our values. ...We dare not disdain the opportunity to breathe and taste even when it is done with difficulty. ...And we have to protect life wherever it is given, whether it is flawed or perfect."(pp.16;22)

Many vacillating attitudes toward the elderly can be traced to America's values system as it has been expressed in past policy debates. The "American Values and the Elderly" project (1979), reported by the University of Michigan Institute of Gerontology, identified a set of seven enduring, discrete, and complementary dilemmas. They appear repeatedly in a variety of old-age programs spanning the decades from the 1930s to the present. The seven pairs are:

a. Self-reliance/dependency, which emphasizes the strain between the desire for autonomy and personal initiative on the one hand and the need to recognize the limits to individual resources and the necessity of relying on others.

b. Struggle/entitlement, which suggests the tension between working for everything we can get and being entitled to certain things because we are human beings or because of some legitimate precedent.

c. Work/leisure, which confronts the issue of work and its meanings for an individual's identity. When should one's pursuit of leisure take precedence over one's duty to work?

d. Individual/family, which underscores the problems of balancing our personal needs and those of the family into which we are born and which we create.

e. Private/public, which describes the conflict between using personal or corporate means and using governmental resources to achieve desirable societal goals.

f. Equity/adequacy, which refers to the policy conflict between fairness to all and the responsibility to help those most in need.

g. Secular/religious, which characterizes the perennial choice which individuals and groups make between looking for new, rational explanations for life's crises and for relying on time-tested sources of support.

Such interaction of values invites ambiguity and conflict, but does not force policymakers to make an either-or choice, thus pitting one group against another (Achenbaum, 1980,10-11). These tensions, properly evaluated and dealt with by legislators and others, can produce an increasingly valid policy on aging. It is important for all involved in policy decisions to be aware that their attitudes toward aging are personal expressions of a value system which consciously or unconsciously will influence the lives of millions of older Americans for years to come (and ultimately themselves).

6. Contribution of the Older Person to American Society

A consideration of the older person's role in society incorporates two elements: the obligations of society to the aging and the obligations of the aging to society. In the latter emphasis the following guidelines should be taken into account:

a. As people live longer, success or failure is predicated upon decisions made throughout one's life. The responsibility to age well involves personal choices and has ethical and spiritual implications not only for the individual, but also for society as a whole (Fahey, 1980,2).

b. Older persons in the future should be challenged to use their gifts to the benefit of the broader society rather than retiring to a life of self-interest.

c. The elderly have a definite advocacy role in identifying and taking initiative in solving their problems, especially in matters of legislation and social justice. This concept goes against the general trend toward dependency in our society; therefore, government and the religious sector have a vital empowerment role to play.

d. It is important that the aging, especially the frail elderly, realize that all persons are born and will die, that dependency and independence are interwoven and natural stages in the lifespan. Role-reversal in care of the frail elderly can evoke growth in human compassion on the part of giver and receiver.

7. Age vs. Need as a Basis for National Policy

There are cogent arguments for both need and age as bases of national policy. Indeed, the ethical, philosophical, and political considerations in shaping such policy are formidable. For example, what new definitions of need would be necessary and who would formulate them if policies were restructured to support the poor, the disabled, the isolated, regardless of age? Substitution of economic need for age-entitlement would raise the question: should old people be required to document poverty status to become eligible for benefits?

On the other hand, as research accumulates, it is becoming obvious that age is a poor predictor of performance, either physical, mental or social. In this sense, age is becoming more irrelevant than it was in earlier periods in America's history (Neugarten, 1979,48;52).

In recommending policy directions for the 1980s, there are other overarching considerations, among them the following:

a. Limits of excellence. The growing expectations of our population during the past 30 years were accompanied by the desire for excellence in setting policy and establishing programs. All things considered, should we adopt an ethic of modified expectations in developing future policy? (Fahey,1980,4-5). Could we live in good conscience, with what this change might mean in the personal and family lives of a large segment of the population? If we must draw lines, upon what ethical and spiritual premises should policies be based?

b. Modes of human interactions. Is our society's penchant for the economic model a sound and sufficient explanation of human interchange? Must we continue to view "production" as the best way to distribute resources in a society? How far do we wish to bring human interaction, often done out of love, friendship, or neighborliness, into a professional, monetized system? (p. 7). Is it time to opt for a more wholistic model, one which truly accepts societal responsibility for those among us who are "non-producers," providing for them in a manner which maintains dignity and acknowledges their intrinsic worth as individuals, however flawed?

CONCLUSION

Because every human act, whether individual or collective, has ethical and spiritual implications, explicit attention must be given in the future to the ethical and spiritual domains of individual, institutional, and societal policy and decision-making. Outcomes should not be left to chance alone (Moberg, 1980,45).

In accord with the growing emphasis upon wholistic orientations in general, the chief goal of all social action, public and private, should be to make wholistic well-being, focused on spiritual well-being and its associated values of human dignity and freedom, a primary concern in both public and private policy. To this end, geri-ethics and the spiritual well-being of the aging and the elderly must receive attention in all academic disciplines and all fields of science associated with gerontology, as well as in all areas of geriatric practice. (p.45)

Significant developments in the areas of spiritual well-being and ethical action have marked the 1970s. The foundation is in place for building national policy which meets future needs of the elderly and which permits contributions of the elderly to our society.

Welton Gaddy (1980) has sounded the call for conscience:

"The aged hold great promise for our society if we will but have the good conscience to lay hold of it. Our manner of response will be indicative of our humaneness or beastiality; our sense of integrity or lack of it. Judgment on our feeling about and interactions with the aged may take the form either of blessing or condemnation. All of the evidence is not yet in." (p.20).

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the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on
Consumer Problems of Older Americans

MCR-20

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

CONSUMER PROBLEMS

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Consumer Problems

PREFACE

On January 29-30, 1981, the National Retired Teachers Association and the American Association of Retired Persons convened a White House Conference on Aging, Mini-Conference on Consumer Problems of Older Americans. Over sixty expert delegates from aging, government, private, and academic organizations participated. The mini-conference was funded by the American Express Company, American Express Foundation, American Telephone and Telegraph, Avon Products Foundation, Inc., Avon Products, Inc., Citicorp N.A., and Food Marketing Institute. Fourteen leading organizations served on an advisory committee which guided delegate selection for the mini-conference. Substantial support was provided by the Federal Trade Commission, the U.S. Office of Consumer Affairs, the U.S. Department of Agriculture and the U.S. Food and Drug Administration. The recommendations which follow do not necessarily reflect the positions of any of the participating organizations.

Consumer Problems of Older Americans

As harmful as inflation is to the purchasing power of the general public, its effects on the elderly are even more dramatic. Over the last ten years, the costs of basic necessities - food, fuel, housing and health care - have been increasing far more rapidly than those of other goods and services. An elderly individual whose income is fixed or partially fixed is clearly being forced to spend more to survive. With a reduced income and the burden of inflation, fraud, deception and failures of the marketplace create an intolerable situation for the older consumer.

The following topics are not inclusive of all consumer problems which affect the elderly. Other important consumer topics such as housing, energy and legal services were dealt with at other mini-conferences.

Credit

Credit has become the key to full participation in the benefits of our society. To many older persons, however, the idea of using credit for the purchase of goods and services is still foreign. For the elderly to be unfamiliar with the benefits and rights, as well as the responsibilities and pitfalls of credit transactions, can put them at a distinct disadvantage in the marketplace. Many of the elderly continue to be treated unfairly in the credit market, despite legislative efforts such as the Equal Credit Opportunity Act.

Food

Americans over age 65 spend roughly 22 percent of their before-tax income on food, compared with about 17 percent for those under 65. Major issues concerning food and the elderly include food price inflation, food advertising, food information, consumer nutrition information, access to food, store layout and services, and eating out.

Insurance

The most troublesome form of insurance facing the elderly is health insurance. Since the enactment of Medicare involved compromise leaving gaps for private health insurance to fill, the sale of Medicare supplement policies has become a big business, which is largely unregulated. Many elderly persons have been sold far more supplementary coverage than needed, and many of these policies have been extremely poor values for their cost. State regulation, consumer education and complex policy language are also major issues in this area.

Investments

Fraudulent investment schemes and deceptive sales methods strike particularly hard at older people. The elderly are often caught in the financial vise created by the combination of declining income and rising expenses. The economic difficulties caused by this situation frequently tempt the elderly to respond to promotions offering the promise of quick financial gain.

Prescription Drugs and Medical Appliances

The elderly are highly disproportionate consumers of prescription drugs and medical appliances. Persons over age 65 comprise 11 percent of the population, but account for 25 percent of the national drug bill. Yet, because so many older persons are on low or fixed incomes, they may be least able to afford the cost of needed prescription drugs or medical appliances.

Primary Health Care Providers

Availability, affordability and accessibility of quality health care services is of particular concern to the older population. The aged population is expected to increase from its current 11.2 percent to 17.2 percent by 2025. This growth will create the need for more primary health care delivery systems designed to provide care to the elderly in our society.

RESOLUTIONS

The following section contains the resolutions that were developed and adopted by work group delegates at the mini-conference.

CREDIT

Preamble

It is recognized that some of the recommendations below may involve at least initial costs to lenders. Although most would benefit all consumers, others would benefit primarily the elderly, and hence, may constitute, in effect, a subsidy to the elderly. If so, the cost is a proper one as part of society's obligation to its elderly population. However, some of the apparent initial costs of recommended changes would in the long run enable lenders to make sounder credit decisions and to offer credit to more people. This would benefit the credit providers by balancing off or exceeding the cost of making the recommended changes.

Resolution Topic: CONSUMER AND PROVIDER EDUCATION ON CREDIT

Statement of Recommendation: Be it resolved that:

1. Educational programs and materials should be prepared and distributed by business, government agencies, educational institutions and consumer organizations to provide the following kinds of information to elderly consumers: (a) whether the use of credit is appropriate; (b) how to shop for credit; (c) credit rights, responsibilities and remedies under Federal, State and local law; (d) common qualifications for credit worthiness.

2. Special efforts should be made to develop creative means of communicating this information, including the use of electronic media, senior centers and organizations, and women's organizations.

3. Special consideration should be given to developing credit education programs geared to foreign language groups and to physically disabled elderly.

4. Educational programs of this nature should also be implemented throughout the educational systems to alleviate credit problems of future generations of elderly citizens.

5. Programs should be developed to ensure that financial institutions, other creditors and government entities concerned with consumer credit are made aware of special needs and characteristics of elderly consumers.

6. With regard to public agencies which make policy decisions in the area of consumer credit, the participation of elderly consumers in the decision-making process should be encouraged.

Resolution Topic: THE ELDERLY'S ACCESS TO CREDIT

Statement of Recommendation: Be it resolved that:

1. Regulation B of the Equal Credit Opportunity Act should be amended to require creditors who deny credit because of insufficient credit histories to inform denied credit applicants of their rights to have applicable spousal credit histories considered.

2. Creditors should be required effectively to give the same weight to other sources of income as is given to earned income. The same standards of reliability should apply to other sources of income as are applied to earned income.

3. Creditors who consider income should be required also to consider assets to determine credit worthiness. Creditors should be prohibited from giving negative weight to multiple income sources.

4. Lenders should facilitate the elderly's access to automatic teller machines (ATMs) and use larger type sizes.

5. Creditors should provide meaningful and specific reasons for denial of credit.

6. A study should be conducted to determine if the elderly have difficulty obtaining credit insurance or other credit-related insurance, and if this has increased the cost of credit for the elderly.

Resolution Topic: CREDIT RIGHTS AND RESPONSIBILITIES

Statement of Recommendation: Be it resolved that:

1. Credit contracts should not contain clauses that give unfair advantages to creditors.

2. The Federal Fair Debt Collection Practices Act should be amended to include collection practices of the original creditor and not to exempt attorneys from the Act.

Minority Opinion: Credit contracts should not contain clauses such as judgments by confession, waivers of exemption, wage assignments, blanket security interests, unrestricted assignment of attorneys fees, excessive late charges or extension fees, pledge of final paychecks, acceleration clauses, payment of collection fees, right to collect deficiency, waiver of right to privacy, cosigner guaranty, continuing cosigner guaranty and insecurity clause.

Resolution Topic: DISCLOSURE OF CREDIT INFORMATION

Statement of Recommendation: Be it resolved that:

1. All financial disclosures should meet the special requirements of the elderly in providing timely notification, in plain language, and in an appropriate type size or outreach medium.

2. Model credit forms and clauses for adoption by creditors should be developed.

Resolution Topic: FACILITATING ACCESS TO HOUSING CREDIT

Statement of Recommendation: Be it resolved that:

1. The elderly should have access to equity in their homes on equitable terms, including second mortgages at fair rates and cost.

2. Reverse annuity mortgages should be more broadly available in a form to allow the elderly to remain in their homes for the rest of their lives.

3. Pension funds should be encouraged to invest in fixed rate mortgages of middle to low income elderly debtors.

4. State home repair programs which contemplate repayment upon transfer of property or settlement of an estate should be expanded.

5. Financing should be available to the elderly to buy new homes, mobile homes, etc., through the use of appropriately structured shared appreciation mortgages.

Resolution Topic: FINANCIAL INSTITUTION RELATIONSHIP AND PROCEDURES

Statement of Recommendation: Be it resolved that:

1. Financial institutions should take care to facilitate the establishment of new or different relationships with elderly consumers.

2. The elderly should have reasonable and free choice in their relationships with financial institutions, particularly in regard to the use of electronic funds transfer (EFT) versus paper-based payment system.

3. Creditors should be sensitive to the unique social needs of the elderly and provide alternative services at fair cost.

4. Educational efforts should be expanded to apprise the elderly regarding the use of new or changing financial products, services and technologies such as EFT, direct deposit, NOW accounts, variable rate mortgages, etc.

5. Creditors should be sensitive in the pricing of financial services, recognizing that many elderly consumers are small savers. Charges to elderly consumers with small savings should be minimized.

FOOD

Resolution Topic: FOOD PRICES AND AVAILABILITY

Statement of Recommendation: Be it resolved that:

1. The limited incomes of some of the elderly should be supplemented through such programs as food stamps, meals on wheels, congregate meals, buying clubs, and food banks to provide for adequate nutrition.

2. A "Golden Food Card" should be issued. It would provide a supplementary resource for food purchases while preserving the older person's dignity and respect, since many older Americans are reluctant to make use of current publicly funded food support programs.

3. Employment, either private or public service, should be available to all who want to work to supplement their income for food purchases and continue their contribution to their community.

4. Greater access to food buying should be provided through extended hours for social agencies and accessibility through special and supplemental transportation or food delivery.

5. National policies must assure the production of an abundant and stable supply of food so that older persons can be assured of the availability of food at affordable prices.

6. Food stamps should be accepted at restaurants and congregate meal centers.

7. Families who help support or maintain older family members within their homes should have access to support services.

8. Minimum housing standards should mandate facilities for safe food preparation including heat, refrigeration and pure water.

Resolution Topic: ALTERNATIVE APPROACHES TO FOOD PURCHASING

Statement of Recommendation: Be it resolved that:

1. Given the trend toward the relocation of stores to inaccessible surburban areas, communities (including business, government and older Americans themselves) should encourage the development and utilization of alternatives to traditional food distribution systems. These alternatives include, but should not be limited to, the following: (a) transportation to food sources; (b) food cooperatives and buying clubs; (c) community gardens, solar energy gardens and hydroponic gardens; (d) food banks and gleaner programs; (e) the delivery of food to shut-ins and senior groups; and (f) support of the development of localized discount food stores, such as warehouse stores, and day-old or "thrift stores."

2. The development of each alternative will require the coordinated efforts of business (for the development of new marketing concepts); government (for tax incentives and removal of regulatory impediments); and older Americans themselves (to recognize they have resources in terms of time and experience to be a motivating force to make these alternatives a reality).

Resolution Topic: CONSUMER EDUCATION

Statement of Recommendation: Be it resolved that:

1. Given the limited food budgets and special nutritional needs of the elderly, training should be provided to those who work with them, including health care professionals and families, on the benefits of nutrition. Existing nutritional education resources should be made available for consumer education programs to meet the special needs of older Americans.

2. Nutritional counseling should be made a reimbursable expense and individual and group counseling should be provided to assist older people with specialized diet problems. An interagency network should be established to develop methods of dealing with this nutritional problem. Emphasis should be placed on preventive programs dealing with nutrition through existing channels of communications. New partnerships should be established between the research and educational communities to accelerate and facilitate effective application of relevant research findings.

3. The presentation of price and nutritional information should be given a high priority. Good buying skills may be encouraged by means of: clear and accurate advertising and labeling; price information that is displayed conspicuously and in a form that is understandable as to content and size and which accommodates the special needs of the elderly, including the visually handicapped; attention to item pricing as a basic consumer right; and support for truth in restaurant menus. There should also be clear disclosure of the net quantity of products on packages and truthful, simple information available as to nutrient values, additives, etc.

4. A model teaching kit for older Americans should be developed to incorporate, but not be limited to, such tools as the following: unit pricing, label interpretation, reading dates, net weight knowledge, substitution of comparable products, brand name versus store name versus generic, coupon and rebate use, comparison shopping through the mails and the understanding of marketing strategies employed by the food industry.

Resolution Topic: NEED FOR FOOD AND NUTRITION RESEARCH, DEVELOPMENT, AND SURVEILLANCE OF HEALTH AND DISEASE PROBLEMS OF OLDER AMERICANS

Statement of Recommendation: Be it resolved that:

Although much is known, gaps exist in our knowledge of the diet and health problems of the elderly. Key areas requiring additional research include: further defining the relationship between diet and degenerative chronic diseases; defining specific nutrient needs for older individuals particularly in the presence of decreased caloric intakes; developing an improved understanding of the dietary patterns and nutritional status of both well and chronically ill older individuals; and developing an understanding of the interaction between foods, nutrients and diets on one hand, and drugs, environmental contaminants and food additives on the other.

Food and nutrition research, development and surveillance as concerned with maintaining health and reducing disease problems of older Americans must be sustained and augmented at all levels of the scientific community. Local, State and Federal governments, as well as the private sector, should increase recognition and support for: the grant, contract and in-house research efforts of agencies such as the National Institutes of Health, Food and Drug Administration, and the U.S. Department of Agriculture (see the December 1980 Report on Human Nutrition and Research and Training by the Office of Science and Technology Policy); similar research supported by the private sector, individual industries and private foundations; efforts at state-supported universities with medical and allied science schools and food and agricultural research capabilities; implementation of the national nutrition status monitoring system recently submitted to the Congress.

Resolution Topic: NUTRITIONAL QUALITY OF FOOD PRODUCTS AVAILABLE TO OLDER PERSONS

Statement of Recommendation: Be it resolved that:

1. The entire food industry should put nutrition in the front seat by giving greater emphasis to nutrition in product research and development, and by focusing much greater attention on marketing and advertising of particularly nutritious food products.

2. Specific nutritional needs of older Americans should be given increased attention in government feeding and information programs.

Resolution Topic: SOCIAL AND EMOTIONAL ASPECTS OF EATING WITH RESPECT TO PHYSICAL HEALTH

Statement of Recommendation: Be it resolved that:

1. The children and friends of older consumers need to be educated as to the importance of the social aspects of eating. They should be aware that eating alone may contribute to deficiencies in diet because of a loss of interest in preparing a variety of foods and poor preparation or serving techniques. They should be taught that the social amenities that accompany the meal (i.e., eating at a set time and washing up) contribute to a person's health.

2. Older persons should be encouraged to develop neighborhood meal exchange activities and dining together.

3. Agencies dealing with the health (psychological as well as physical) of the elderly should be made aware of the importance of including social interactions as part of all aspects of programs dealing with the elderly -- congregate meals, meals on wheels, meal cooperatives, nursing homes, and senior citizen congregate housing.

4. Consumer representatives in the food industry should use advertising which shows dining together. Restaurants and other food providers should encourage group dining. Packaging should be designed to facilitate convenient group food preparation.

5. Additional research should be undertaken in this area.

INSURANCE

Resolution Topic: PUBLIC PARTICIPATION IN THE INSURANCE REGULATORY PROCESS

Statement of Recommendation: Be it resolved that:

The uniqueness of different state regulatory processes requires that a number of approaches be used to expand public participation in the insurance regulatory process. The method chosen by each state should meet the following criteria: (a) it must be an ongoing process; (b) knowledgeable consumer representatives must be involved; and (c) funding should be provided to accomplish (a) and (b). The goal of increased public participation will only be met if the above criteria are met and if groups mobilize to take advantage of these new opportunities, as well as the traditional methods of making one's voice heard. Training of these representatives should also be provided to make their input more effective.

Resolution Topic: POLICY LANGUAGE

Statement of Recommendation: Be it resolved that:

1. Insurance policies should be written in clear, concise, understandable language.

Resolution Topic: PHYSICIAN ACCEPTANCE OF MEDICARE ASSIGNMENT

Statement of Recommendation: Be it resolved that:

1. Serious attention be given to a possible revamping of the process of setting reimbursement rates.

2. Incentives should be found to encourage higher participation by physicians.

Resolution Topic: MEDICARE CARRIERS

Statement of Recommendation: Be it resolved that:

1. Existing laws and regulations should be reviewed to insure that proper safeguards exist in instances where Medicare intermediaries also market Medicare supplemental insurance policies.

Resolution Topic: INADEQUATE EXAMINATION OF POTENTIAL FRAUD OR INACCURACIES

Statement of Recommendation: Be it resolved that:

1. The Federal Government should allow more generous payment to provide the intermediary and carrier with greater incentive to screen claims for fraud and accuracy, and then insist that adequate screening is conducted before claims are paid.

INVESTMENTS

Resolution Topic: REGISTRATION OF FINANCIAL PLANNERS AND ESTATE PLANNERS

Statement of Recommendation: Be it resolved that:

1. Financial planners and estate planners should be held to a standard of competency through state registration.

2. Each state should establish a board consisting of lay persons and experts in the field of financial and estate planning who would review, upon complaint, the competency of the registrant.

Resolution Topic: NEED FOR CONSUMER EDUCATION

Statement of Recommendation: Be it resolved that:

1. All sectors, at all levels of government, educational institutions, private industry, the news media, senior citizen centers, and other private groups work to improve the delivery of accurate, simplified information, in all widely used languages, on investments and personal financial counseling for older Americans.

2. Methods to be considered should be the development of a source handbook tailored to older Americans where necessary.

Resolution Topic: INVESTMENT INFORMATION: COST AND ACCESS

Statement of Recommendation: Be it resolved that:

1. Organizations such as competent investment clubs should be encouraged for the benefit of the elderly who have not been exposed to sophisticated financial language and procedures.

2. The cost of assuring access to information for investment should be supplied by Federal or State agencies in conjunction with private industry and trade associations.

Resolution Topic: NEED FOR PLAIN LANGUAGE DISCLOSURES AND DEVELOPMENT OF A GLOSSARY

Statement of Recommendation: Be it resolved that:

1. In investment transactions full disclosure should be promoted in simplified language taking into consideration cultural background and level of education.

2. A glossary of definitions of basic terms used in investment programs should be developed based on cultural background and educational level as well.

Resolution Topic: REAL ESTATE FRAUDS

Statement of Recommendation: Be it resolved that:

1. Existing disclosure requirements are presently inadequate and should be more detailed to disclose such things as who gets exact fees and commissions, up-front costs, and securing deposits in escrow and interest-bearing accounts.

2. Jurisdiction should be expanded to permit Federal, State and local agencies to address deceptive sales and advertising practices.

3. There should be adequate bonding requirements to ensure satisfactory completion of sellers' promises and legal obligations.

Resolution Topic: LACK OF EFFECTIVE ACCESS TO COURTS

Statement of Recommendation: Be it resolved that:

1. In transactions involving investments by the elderly and certain dollar amounts, the contract should provide for a dispute resolution system which is fast, low cost, easily accessible and fair, such as arbitration, small claims courts, night and weekend courts.
2. Aging organizations should create group legal services programs for their members.
3. The expertise of retired lawyers should be utilized in the same way that the expertise of retired executives is now used.
4. Programs in existence today, such as third-party dispute resolution, arbitration and mediation, should be adequately funded, staffed and fully implemented.

PRESCRIPTION DRUGS AND MEDICAL APPLIANCES

Resolution Topic DRUG COSTS

Statement of Recommendation: Be it resolved that:

1. State generic drug laws should be amended and standardized to include the following conditions: (a) Prescribers should be required to provide in their own handwriting whenever drug product selection is to be prohibited; (b) In order to provide an incentive for drug product selection, the laws should provide a sharing of savings between consumers and pharmacists, with a substantial majority of savings being passed on to the consumers; (c) The laws should provide for generically written prescriptions that the lowest priced product, consistent with professional judgment, should be dispensed; (d) State laws should provide for educational programs directed at both consumers and professionals to encourage greater use of lower priced generically equivalent drug products.
2. The White House Conference on Aging should call for the establishment of a committee, including both private and public representatives, to produce a draft of a model drug product selection bill which would be submitted to all of the states.

3. To encourage greater use of lower-cost, generically equivalent drug products, prescription drugs should be included as a covered benefit under the Medicare program.

Minority Opinion: Including prescription drugs under Medicare at this time would introduce a danger of overprescribing. Alternate methods of prescription drug cost containment should be evaluated, and other mechanisms, such as patient responsibility for a portion of drug costs, should be established.

Resolution Topic: CONSUMER EDUCATION

Statement of Recommendation: Be it resolved that:

1. Consumer education should be supported and encouraged at all levels to provide elderly consumers with the facts on: (a) how medications and medical devices work and their limitations (e.g., that drugs are often not appropriate); (b) the proper utilization of drugs and medical devices and how to avoid common medication problems; (c) how to ask questions of and communicate effectively with physicians, suppliers of medical devices, and pharmacists; (d) how to save money on medical devices and medications by comparison shopping and utilizing generics; (e) rational preventive care skills and use of over-the-counter drugs; (f) how to recognize and resist deceptive advertising practices and quackery.

2. These skills and information should be made available through: (a) easily readable labels, patient package inserts (PPIs) in language lay people can understand, explanations by the physician at the time of prescribing, and the use of patient profiles; (b) training to help professionals, emphasizing respect for consumers and the importance and skills of communicating clearly; (c) special training for senior leaders, and the use of senior centers and other community organizations, such as libraries and schools, as a source of information; (d) the establishment of impartial information centers reachable by toll-free numbers.

3. Consumer protection agencies at all levels should make greater use of publicity to combat fraud and advance consumer interests.

Minority Opinion: Printed information should not be limited solely to PPIs. Instead, alternate methods to describe proper drug use and possible adverse reactions to consumers should be developed which are less expensive than PPIs and which provide drug information before rather than after the drug has been purchased.

Resolution Topic: DECEPTIVE ADVERTISING OF DRUGS

Statement of Recommendation: Be it resolved that:

1. The Federal Trade Commission should study the issue of whether or not television advertising encourages the use of nonprescription drugs when they are not needed by the individual, and examine if, in fact, they may be harmful.

2. The FTC should examine deceptive advertising regarding false claims in medical results and in cost savings.

Resolution Topic: PRESCRIBING OF DRUGS AND MEDICAL DEVICES

Statement of Recommendation: Be it resolved that:

1. The Department of Health and Human Services should investigate patterns of prescribing with the view to encouraging a more rational prescribing of prescription drugs to achieve more appropriate care as well as a means of cost savings.

Minority Opinion: A prescribing physician or associate should not be involved, directly or indirectly, with the sale of the prescribed product or device. If he is involved in the sale of medical devices or drugs, he should be qualified as to competency by passing an examination required by a licensing board or regulatory body pertaining to fitting and dispensing of the devices or products, and should be obligated to disclose that he is also a salesperson.

Resolution Topic: SENIOR CONSUMER COOPERATIVES

Statement of Recommendation: Be it resolved that:

1. The National Consumer Cooperative Bank should be strengthened to serve the needs of consumers by providing sound loans and technical assistance for drug and health care cooperatives.

Resolution Topic: CONSUMER PARTICIPATION

Statement of Recommendation: Be it resolved that:

1. Effective participation of consumers should be encouraged by requiring at least 50 percent of the members of licensing and regulatory boards be public members.

2. Such public members should represent consumer organizations and receive training and support necessary to fulfill their role.

Minority Opinion: The control of licensing and regulatory boards should remain within the professions. Consumers should be adequately represented on these boards, but should not constitute 50 percent of their composition.

PRIMARY HEALTH CARE PROVIDERS

Resolution Topic: AVAILABILITY OF HEALTH-RELATED SERVICES

Statement of Recommendation: Be it resolved that:

1. The following services should be made available and fully reimbursed by public funding, and all third-party sources should also be encouraged to reimburse: preventive services (including but not limited to immunizations, nutrition and counseling and nutritional supplementation, physical exams, screening tests, foot exams, and vision and hearing tests); health maintenance; care of chronic conditions; podiatry; dental, optical, and audiology services; mental health services and coordination of social services.

2. In order to provide coordination of services, support should be increased for community health centers, rural health centers, urban health centers, etc. These centers should be directed to provide coordinated health services for the elderly. Increased support for hospital-based ambulatory geriatric centers and the expansion of voluntary service agencies to more comprehensive services should also be encouraged.

3. Increased support should be provided for senior citizen programs, mutual aid groups, meals on wheels, and other such programs.

Resolution Topic: INCREASING THE ABILITY OF THE ELDERLY TO REMAIN AT HOME AND WITHIN THE COMMUNITY

Statement of Recommendation: Be it resolved that:

1. The support services for families caring for disabled elderly at home should be broadened through expansion of programs of home health aides, trained homemakers, hot lines, and continuing education for families of the homebound.

2. Direct financial support for these services should be established. Tax credits should be given to families that maintain disabled elderly within the home. Senior citizen centers, day care centers, mutual aid groups, meals on wheels should receive increased support.

3. The Administration on Aging-National Clearinghouse on Aging should be instructed to prepare a series of booklets in multiple languages covering care of homebound and for the elderly consumer on health issues.

4. Increased support should be given to health-related facilities and congregate housing for elderly.

Resolution Topic: REMOVAL OF BARRIERS TO ACCESS FOR ALL HEALTH SERVICES

Statement of Recommendation: Be it resolved that:

1. The Federal government should continue to support rural health clinics, urban community health centers and hospital-based ambulatory centers to provide health care by a full range of health providers.

2. A system of transportation should be established to transport patients (elderly and disadvantaged) to the nearest appropriate medical facility for primary care as well as emergency care. This should include reimbursement for mobile services or outreach services from a clinic or hospital. The Internal Revenue Service should be mandated to allow as deductible items transportation for patients and their families.

3. The Federal government should be encouraged to continue the National Health Service Corps as an agent for promotion of health services for rural and urban communities designated as underserved areas.

4. Medicare (Title XVIII) should be mandated by regulation to reimburse for nurse practitioners and/or physican assistant services.

5. States should be encouraged to allow nurse practitioners and physician assistants to practice by appropriate laws or regulations.

6. The Federal government through health and social services should provide for translation services for ethnic groups who cannot communicate in English.

7. The Federal government by either a tax credit and/or special reimbursement should encourage architectural renovation for access to private offices for handicapped persons.

8. Federal and State health service programs should be encouraged to select a greater number of applicants from rural and urban areas and minority groups since these individuals are most likely to provide services in the future for the medically underserved.

Resolution Topic: COST REIMBURSEMENT AND FINANCIAL ACCESS TO PRIMARY HEALTH CARE

Statement of Recommendation: Be it resolved that:

1. A system should be developed for the publication of a medical directory listing of physicians, their specialties and standard charges.

2. The present reimbursement system should be canceled and a more equitable system of medical reimbursements developed.

3. Nurse practitioners should be reimbursed directly for primary care provided under the care of licensed physicians.

4. State insurance commissioners should be urged to encourage third-party insurers to comply with (2) and (3) above.

5. Any physician serving any person entitled to Medicare benefits should be required to accept the new equitable reimbursement rates as full payment.

Minority Opinion: Physicians who take assignment should have to accept the new rates as full payment; but those physicians who do not take assignment should not be required to accept these rates as full payment.

Resolution Topic: BARRIERS TO THE ENTRY OF NEW PROVIDERS

Statement of Recommendation: Be it resolved that:

1. States should review the criteria on the admission of out-of-state physicans into practice within the state.

2. States should be encouraged to pass laws permitting the practice of nurse practitioners or other alternate health care providers, assuring that such laws assure adequate quality of practice in those fields.

Resolution Topic: IMPROVED EDUCATION ON THE MEDICAL NEEDS OF THE ELDERLY

Statement of Recommendation: Be it resolved that:

1. Medical training in both continuing and primary courses should include treatment and care of the elderly. Local and state medical societies should be encouraged to provide this educational component.

Resolution Topic: ENFORCEMENT OF THE EXISTING INSURANCE LAWS AND REGULATIONS

Statement of Recommendation: Be it resolved that:

1. State agencies with enforcement responsibilities should establish a formal mechanism to assure coordination of enforcement activities, such as establishing an ad hoc commission comprised of State enforcement agencies, industry and elderly consumers to recommend methods to improve operation.

2. Adequate funding should be allotted to state enforcement agencies to enable them to more effectively administer existing statutes.

3. States should be encouraged to pass legislation to deal with the medigap problem, and at a minimum they should meet those standards established in the Bachus Amendment.

4. Legislative and regulatory bodies are continually faced with a decision as to whether a particular insurance product ought to be banned or whether its attributes ought to be adequately disclosed to prospective buyers. Each issue needs to be examined case-by-case; however, at the very least, adequate disclosure, including standardized disclosure forms, should be assured. States should be encouraged to examine the adequacy of their laws and regulations relating to all kinds of health insurance for the elderly.

5. States should be encouraged to actively establish and support effective no-fault auto insurance legislation.

Resolution Topic: CONSUMER EDUCATION AND INFORMATION FOR ELDERLY INSURANCE CONSUMERS

Statement of Recommendation: Be it resolved that:

1. Establishment of local consumer information systems to enable the elderly to obtain information on insurance should be encouraged. This should include strong volunteer support systems which incorporate industry resources.

2. More reliable consumer information on Medicare and other forms of insurance are needed.

3. Local peer counseling services should be encouraged to provide older persons with information on, and assistance with, insurance-related concerns. Counselors should be sufficiently trained and supervised to assure accuracy of information.

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the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on the
Rights of the Institutionalized Elderly
and the
Role of the Volunteer

MCR-21

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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INTRODUCTION

The National Citizens' Coalition for Nursing Home Reform, the National Senior Citizens Law Center, and the National Gray Panthers co-sponsored a Mini Conference on "The Rights of the Institutionalized Elderly and the Role of the Volunteer," January 23, 1981. The objectives of the conference were 1) to provide important information on residents rights issues and activities, 2) to provide model information on volunteer activities, 3) to provide conference participants an opportunity to discuss these issues and activities, and 4) to develop and adopt recommendations for the 1981 White House Conference on Aging.

The Coalition and the Gray Panthers have supported local, state and national efforts to strengthen and promote laws and regulations to assure and maintain rights for long-term care residents. They have been active in educational and training events to motivate citizens and groups to support resident rights and to volunteer their services to residents and long-term care providers.

Most importantly, they have recognized and advocated for self-determination and self-advocacy for long-term care residents. All three organizations maintain that the ultimate outcome of any strong resident rights law, regulations, or activities will be the development of an institutional environment which fosters maximum opportunities for resident decision-making and involvement in the daily life of a long-term care facility. It was with this basic premise that the conference idea and program was conceived, planned and conducted.

This report describes the conference proceedings and offers the conference recommendations for consideration by delegates of the White House Conference on Aging.

MAJOR ISSUES

The conference opening panel focused on four primary issues:

*The rights of residents in long-term care facilities

*Participation by residents in resident councils and community life

*Community education and volunteer recruitment programs

*Training and supervision of volunteers

Resident Rights

Panelist: Toby Edelman, National Senior Citizens Law Center

Nursing home residents do not lose their human or Constiutional rights when they enter a long-term care facility. However, the fact of institutionalization, combined with the particular dependency and vulnerability of institutionalized elderly people, too often results in infringement of basic rights. This infringement has led to the enactment of bills of rights for nursing home residents, first at the federal and later at the state levels.

The first federal bill of rights in the mid 1970's largely expressed First Amendment rights and liberties, addressing such concerns as the right to meet with people, to exercise rights of citizenship, to enjoy religious liberty, and to receive and send mail unopened. More recent state laws have expanded the protected rights to include financial issues and the right to receive health care in a facility meeting federal and state standards. Recent state laws have also recognized the need for strong and varied mechanisms to enforce protected rights.

The specific resident rights issues discussed at the conference were 1) discrimination based on race, color or national origin (prohibited by Title VI of the Civil Rights Act of 1964); (2) discrimination based on handicap (prohibited by §504 of the Rehabili-Act of 1973); 3) involuntary transfer of residents; 4) access to facilities for members of the community; and 5) Medicaid discrimination (discrimination based on source of payment).

Resident Participation in Resident Councils and Community Life

Panelist: Joan Knowlton, Secretary, Nursing Home Residents Advisory Council, Minneapolis, Minnesota

As a means of helping to ensure their rights, many nursing home residents across the country have formed resident councils. Such councils are most effective when residents are fully in control of their activities and when residents are given support from the community and the facility for such activities.

Residents can provide valuable information about personal experiences and ideas for improving the quality of life and other conditions in long-term care facilities. For example, in the States of Minnesota and Washington, residents serve on important boards and committees such as the Professional Standards Review Organization and the State Nursing Home Advisory Council appointed by the governor.

Community Education and Volunteer Recruitment

Panelist: Iris Freeman, Nursing Home Reisdents' Advocates, Minneapolis, Minnesota

Resident rights are difficult to implement unless residents and the general community are educated about issues of concern to residents and nursing home standards. Community groups have tried various techniques, such as consumer guides, slide shows, group discussions, media work, etc., to inform the general community about the rights of the institutionalized elderly. Community education efforts are often designed to recruit volunteers who can assist in activities related to residents rights - including resident education and self-advocacy by residents.

Volunteer Training and Supervision

Panelist: Roberta Nevitt, Director, Nursing Home Advocacy Project, Maryland Conference of Social Concerns

Voluntary community involvement with nursing home residents is necessary both for social contact and to advocate for and with the residents. Such volunteer involvement is beneficial to the institution and to the community. Adequate and appropriate screening, training and supervision of volunteers improves the level of service the volunteer renders and provides the support necessary to retain volunteer involvement.

CONFERENCE PROCESS

The one-day conference was structured to solicit participation from over 175 registrants. An opening panel, providing an overview of the four main conference issues, was followed by four workshops. Each workshop focused on one of the four issues, with a panel presentation of specific aspects of the issue and group discussion.

Each workshop then developed recommendations. The recommendations receiving a consensus opinion or majority approval were adopted and presented to the entire conference body for general approval. Participants were invited to submit any differing viewpoints or recommendations to the sponsoring groups for consideration. No additional recommendations or comments were received by mid-February. At the conference, participants were given a package of comprehensive materials relating to residents rights issues and activities. Keynote speeches given by Congressman Ron Wyden, Oregon, and Maggie Kuhn, convener of the National Gray Panthers, are summarized at the end of this report.

WORKSHOP SUMMARY: Residents Rights: Issues and Implementation

Panelists: Moderator, Trish Nemore, National Senior Citizens Law Center; Ann Wyatt, Assistant Administrator, Village Nursing Home, New York City; Joselle Holmes, Cape Cod Nursing Home Council; and Tom Herrmann, U.S. Department of Health and Human Services.

Access: A nursing home administrator advised that her "problem" with access is getting more people to come into the home to visit, not keeping people out, as industry representatives sometimes claim. This view and the attendant discussion led to the agreement that the community should have access to a nursing home, and the residents should have access to the community.

Transfer: The disorienting and traumatic effects of transfer were presented by a resident who has been transferred more than five times in her twelve years in nursing homes. Adequate procedural and substantive protections, including consideration of the effects of the transfer on the residents, must be provided to all residents, it was agreed by participants.

Changes in the type or amount of care a person needs can lead to transfer. One administrator recommended providing the care in the same bed rather than moving the resident.

Admissions: Another speaker noted that some admission policies of nursing homes frequently result in effectively barring certain groups from entering a facility. Among those most likely to suffer from these policies are people requiring more than routine care; Medicaid recipients; minorities; handicapped elderly; those with a history of mental illness or alcoholism, and the retarded. A participant remarked that these persons are those most in need of long-term care. One panelist stated that some federal efforts are now underway to investigate whether restrictive admission policies may be civil rights violations.

Participants agreed that laws should be passed to protect against discrimination based on source of payment and that existing federal laws protecting civil rights of the groups identified should be more strictly enforced.

Discussion: Panelists commented on the need for access, some problems with transfer, the considerations in deciding to serve hard-to-care for people, and the enforcement of federal laws protecting civil rights of the elderly.

WORKSHOP SUMMARY: Resident Participation in Resident Councils and Community Life

Panelists: Moderator, Fran Sutcliffe, Nursing Home Hotline Patrol, St. Petersburg, Florida; Joan Knowlton, Nursing Home Residents Advisory Council, Minneapolis, Minnesota; Gary Anderson, Director, American Association of Homes for the Aging, resident council project; Goldsborough Griffith, resident, Fernwood Home, Bethesda, Maryland; Tricia Wittmann-Todd, King County Coalition of Nursing Home Resident Councils; and Harvey Wertlieb, Administrator, Randolph Hills Nursing Home, Wheaton, Maryland.

Discussion: The panelists discussed the benefits and role of a nursing home residents council and the role of staff and volunteer advocates and ombudsmen.

Benefits of a resident council include: provides group support; develops leadership skills; disseminates outside information among people in the facility; brings certain problems to the attention of staff, ombudsmen and family members.

One panelist advised that it is necessary for staff to be trained regarding resident council activities. A supportive staff person can provide encouragement, ideas and information.

Another panelist pointed out the growth in the number of resident councils, including area or regional coalitions of councils and a National Coalition of Resident Councils, based in Minneapolis.

One panelist reported on the results of a survey, conducted by the American Association of Homes for the Aging, which has identified a variety of different types of councils and resident committees. He also advised that some nursing homes are offering special opportunities for resident involvement, including participating in activities of the institution's governing body.

One panelist noted that it is the job of the volunteer advocate, ombudsman or long-term care staff member, to give residents the tools they need to work for themselves. Some of those tools include a constant flow of information, newspapers, outsiders to provide materials and ideas; mobility and transportation to go outside the facility to public meeting, and access to a telephone. She noted that residents could provide important advice to help improve living conditions and services, if they have the tools and support at their disposal. They can become or remain active citizens advocating for better community life for all citizens. She indicated that the bottom line is that the residents need to take the power to implement their own rights.

WORKSHOP SUMMARY: Community Education and Recruitment Programs

Panelists: Moderator, Betty Hamburger, Maryland Advocates for the Aging, Baltimore, Maryland; Ms. Pete McWilliams, Concerned Relatives and Friends of Nursing Home Residents, Ft. Collins, Colorado; Madalyn Turnbull, Volunteer Coordinator, Montgomery County Long-term Care Ombudsman Program; Fern Evans, Interfaith Friends, Wilkes-Barre, Pennsylvania; Janet Tulloch, author, A Home is Not a Home, resident, Washington Home, Washington, D. C.

Discussion: The importance of informing and educating the community about the rights of long-term care residents was underscored by workshop participants. Several panelists addressed the nuts and bolts of public information techniques and methods, such as pamphlets, flyers, public meetings, radio, television, and newspapers.

One panelist emphasized that once educated to the needs of long-term care residents, members of the community may be recruited as volunteers. Volunteers from the community can alleviate the isolation residents experience and can help educate the residents and staff about residents rights. The panelist described several case histories in which the residents improved physically and socially because of regular visits of community volunteers.

Another panelist emphasized the need for educating resident councils and family members about resident rights issues and problems, including misuse of residents personal spending money; denial of residents right to register to vote; the abusive treatment of some workers; the existence of unsanitary conditions and the lack of supervision and training of staff. Resident councils and family groups who are aware of their rights can help solve such problems.

Ms. Tulloch, who has written a book on nursing home life for public education, told the participants about her goals in writing the book and the difficulties she faced during its work. Enlightened and educated workers were necessary to provide her the support and assistance she needed.

WORKSHOP SUMMARY: Training and Supervision of Volunteers

Panelists: Moderator, Vashtye Ferguson, National Citizens' Coalition for Nursing Home Reform; Mary Lou Mooney, Area Ombudsman, Nursing Home Ombudsman Program of Lower Eastern Shore Maryland; Janice McGillik, Illinois Citizens for Better Care; Judy Zepp, resident, Bethesda Health Center, Bethesda, Maryland; and Helen Kelly, Director, Older Americans Volunteer Program, ACTION, Carter Administration.

Discussion: The panel discussed principles governing volunteerism; the need for training of volunteers; and the content of one training program for volunteer advocates.

Volunteerism is a means through which citizens can gain power. The public must be better educated about opportunities to volunteer. To be effective, volunteers need training. Training increases the volunteers level of knowledge and improves skills.

One panelist outlined the training content specifically designed for a volunteer ombudsman program. The training goal was to help the volunteers to think like advocates. Volunteers need specific information so they can respond to grievances of the residents. The following basic information is needed by a volunteer in a long-term care facility:

-types of long-term care facilities available
-normal characteristics of the aging process
-social, psychological and physical needs of the institutionalized aged compared with other aged
-techniques for communicating with and interviewing the aged
-procedures for investigating grievances of residents

-procedures for documenting grievances according to program guidelines
-concepts of involvement for community volunteers, residents, and family members
-long-term care advocacy issues

Do's and Don'ts regarding the training of volunteers included: don't overload the volunteer with information; do use local resources for training; and do screen volunteers before training.

A panelist who addressed the management of volunteers emphasized the following:
-volunteers should relate to only one staff supervisor
-hours should be flexible to meet the volunteer's schedule
-the more meaningful the work, the more apt the volunteer will continue the program
-non-traditional volunteers, such as the elderly, the institutionalized and males can be very effective
-volunteers are capable of a wide variety of responsibilities, including the supervision of other volunteers; assisting a facility with reception activities to help receive community visitors; and vocal advocacy on behalf of the residents
-volunteers are cost effective if well trained and professionally oriented to their jobs

The panelists indicated that denial of access to long-term care facilities is sometimes a primary cause of failure for some volunteer advocacy programs.

The nursing home resident panelist described her opportunity to do volunteer work through the Retired Senior Volunteers Program.

CONFERENCE RECOMMENDATIONS

The Conference participants made the following recommendations:

A. The Right to Long-Term Care

1. Rights of Persons

a. Every person should have the right to receive appropriate long-term care in his/her community or in an institutional setting, as needed.

b. Every person needing institutional long-term care should have the right to exercise personal choice in selecting the facility in which he/she will reside.

2. Actions to implement those rights

a. Reimbursement for care paid for by public programs should be adequate to ensure residents' rights, including the right to quality long-term care. Reimbursement methods should ensure that funds are directed toward resident care and that public accountability (e.g., through audits and public access to cost reports) is provided.

b. The federal government and each state government should, through legislation and regulation, 1) require long-term care facilities to admit residents on a first-come first-served basis, without regard to source of payment, 2) prohibit such facilities from transferring or discharging residents who convert from Medicare or private-pay status to Medical Assistance; 3) require that residents' beds be automatically reserved during periods of hospitalization. If the resident's hospitalization exceeds the reimbursable number of days, the residents must be given priority over new admissions to the facility.

B. The Right to Quality Care

1. Every long-term care resident has the right to live under conditions which promote human dignity and foster human development.

2. Every person should have the right to receive income sufficient to purchase services for basic needs.

3. The federal government and each state should encourage community based long-term care services, both institutional and non-institutional.

4. The federal government and each state should require, as a condition of federal financial participation and/or licensing, that facilities encourage and assist residents in organizing resident councils. Such encouragement and assistance should include, but not be limited to, the provision of adequate space, clerical support and privacy for telephone conversations.

5. The federal government and each state should, as a condition of federal financial participation and/or licensing, require safeguards for residents threatened with any kind of transfer. Such standards should provide due process protections, including detailed notice, the right to a hearing and the right to have the possibility of transfer trauma considered. These standards should also require each state to develop a transfer plan which includes counselling at both locations and pre-transfer visits to the new location.

6. The federal government and each state should abolish the distinction between skilled and intermediate care and, until this abolition occurs, should require that all skilled facilities also provide intermediate care.

C. The Right to Participate in the Life of the Community

1. Rights of Persons

a. Long-term care residents should have equal opportunities for volunteering as are available to other segments of the population.

b. The valuable contributions and resources provided by long-term care residents who volunteer their time in the long-term care institution and community should be recognized and supported.

2. Actions to Implement Rights

a. Elected public officials and state and local regulatory agencies and bodies should be required to solicit involvement of long-term care residents, their friends, relatives, concerned citizens, advocacy groups and facility workers on boards, committees, task forces, and other decision-making bodies. The requirement for open meetings, public notices, access to cost reports and other public documents should be enforced.

D. The Right to Access to the Community

1. Rights of Persons

a. Every institution providing long term care should afford access to the community by residents and by the community to the residents.

b. Federal laws requiring equal access to transportation for the handicapped should be strictly enforced.

2. Actions to Implement Rights

a. The federal government and each state should require, as a condition of federal financial participation and/or licensing, that each long-term care facility provide access to residents for ombudsmen programs and for community and advocacy groups providing free services to residents.

E. The Right to Protection and Enforcement of Rights

1. The federal government and each state should enact legislation and/or regulations establishing a Bill of Rights for long-term care residents. These bills of rights should include a variety of intermediate enforcement sanctions, including complaint handling and other administrative mechanisms, civil and criminal penalties, receivership and a private right of action.

2. The federal government should strengthen enforcement of civil rights laws, especially the Institutionalized Persons Civil Rights Act of 1980, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Developmental Disabilities Assistance and Bill of Rights Act, as they pertain to the rights of long-term care residents to be admitted to and provided quality care in facilities in a non-discriminatory manner.

3. The federal government (Department of Health and Human Services) should revise federal conditions of participation for long-term care facilities to promote a resident care oriented survey and certification process and to emphasize the importance of residents' rights.

4. Congress should reauthorize and expand funding for the Legal Services Corporation in recognition of the essential contribution of legal services programs to the protection and enforcement of residents' rights.

5. Congress should reauthorize the Older Americans Act with expanded funding for advocacy, ombudsman programs and legal services programs in recognition of the essential contribution of these programs to the protection and enforcement of residents' rights.

6. The involvement of the VISTA program and Older American Volunteer Programs under ACTION should continue and be expanded in recognition of the essential contribution of these programs to the promotion, protection and enforcement of residents' rights.

F. Community Education and Training Programs

1. The Health Care Financing Administration, HHS, the Federal Trade Commission and other agencies responsible for long-term care policy should develop and implement consumer education, information and programs addressing residents' rights and other long-term care issues.

2. The aging network and labor unions should be encouraged to provide public information and education regarding the working conditions and concerns and contributions of workers in long-term care facilities.

3. The aging network should encourage the development of community education programs on residents' rights through senior centers, libraries, public schools, churches, and other community agencies.

4. The federal government and each state should require and fund a minimum of 30 hours professional pre-service training of aides and orderlies in long-term care facilities.

5. The federal government and each state should require that federal and state agency officials involved in long-term care enforcement complete training in residents' rights, residents' concerns and the involvement of families and advocacy groups in the enforcement process.

6. The federal government and each state should require the development and enforcement of initial and continuing in-service training for all long-term care staff members on residents' rights and related resident care issues.

SUMMARY OF THE OPENING KEYNOTE ADDRESS: A BILL OF RIGHTS FOR RESIDENTS

Speaker: Congressman Ron Wyden, U.S. House of Representatives, Portland, Oregon

According to Congressman Wyden, who was a co-founder of the Portland Gray Panthers, the essence of a good Residents' Bill of Rights is that it gives the residents and the community access to each other. Nursing home care will not improve until the community is educated and involved. A Residents' Bill of Rights which allows greater access to the nursing home makes community education easier.

Moreover, residents' rights are cost-effective in that they extend the role of the volunteer. In addition, they help strengthen family ties.

The use of volunteers can provide local oversight of services and lead to strengthened local controls.

Congressman Wyden maintained that there is no shortage of people willing to speak up on legislation for senior citizens. He advised that political change starts at the grass roots and moves up. When enough elected officials hear from the public, the system will respond to local needs for improvements in long-term care facilities and services.

The Congressman urged the participants to continue to advocate for stronger federal regulations which include improved residents rights provisions.*

*On January 19, 1981, outgoing Secretary of Health and Human Services, Patricia Harris, signed proposed patient rights regulations for intermediate and skilled nursing home facilities. This action would have elevated minimal existing standards on patients rights to a full condition of participation in federal Medicaid and Medicare programs. On January 21, 1981, new Health and Human Services officials withdrew these regulations signed by the previous Secretary. The Department advised that the proposed regulations needed additional study to assess the potential impact on both providers and consumers of health care. This action came at the end of almost three years of work on the proposed regulations with substantial public support for strengthened residents' rights standards.

SUMMARY OF CLOSING KEYNOTE ADDRESS: A NEW AGE OF SELF-DETERMINATION

Speaker: Maggie Kuhn, Convener, National Gray Panthers

Ms. Kuhn encouraged the conference participants to think of this time as a new age of self-determination and freedom. Residents of long-term care facilities must be provided the opportunities for self-expression and freedoms that the general public enjoys. Residents often are victims of agism which can be compared to sexism and racism. The speaker urged participants to advocate for an end to these social ills.

It is important to cultivate new allies which can include church groups, students in the professional schools, and progressive providers of health care.

New approaches must be used to get residents excited about something other than their own narrow orbit. Facility horticultural programs emphasizing energy preservation were mentioned as an example of a program which can provide new opportunities for challenge and involvement by residents. It is often little things that enlarge our minds and spirits and give us a new agenda.

Residents must be given the opportunity to participate directly in major decisions affecting their daily lives in institutions. Church facilities, in particular, must be encouraged to appoint residents to their governing boards.

In the final analysis, nursing home reform, emphasizing residents' rights, bears directly out of reform of the whole health care system. A national health service is needed which will afford all citizens the same opportunities for comprehensive quality health care as is enjoyed by members of Congress, members of the armed forces, and selected elected officials.

Report of Meeting with New Administration Officials

The speaker informed the conference participants that earlier in the day, she and twelve other conference participants attended a meeting with new administration officials at which time concerns about the proposed regulations for residents' rights for Medicaid and Medicare facilities were discussed. The delegation had asked new officials for a general commitment, in principle, to residents' rights. Ms. Kuhn reported to the conference that the group did not get that assurance, although it did depart with the understanding that continuing communication on the issue would be possible. The two nursing home residents at the meeting, Joan Knowlton of Minnesota, and Phyllis Murphy of Massachusetts, provided valuable information and recommendations on residents' rights issues.

STATE AND LOCAL REGISTRANTS

California
Citizens for Better Nursing Home Care

Colorado
Concerned Relatives and Friends of Nursing Home Residents

District of Columbia
Project Care
D.C. Office on Aging
Legal Counsel for the Elderly
Washington Home
D.C. Village
Washington Center for Aging Services
Metropolitan D.C. Gray Panthers

Florida
Nursing Home Hot-Line Patrol

Illinois
Illinois Citizens for Better Care

Maryland
Montgomery County Long Term Care Ombudsman Program
RSVP, Montgomery County Division of Elder Affairs
Fernwood Home
Maryland Advocates for the Aging
Nursing Home Ombudsman Program of the Lower Eastern Shore
Bethesda Health Center
Outreach, Montgomery County Dept. of Elder Affairs
Baltimore County Association of Senior Citizen Organizations, Inc.
Randolph Hills Nursing Home
Nursing Home Ombudsman, Maryland Office on Aging
Nursing Home Advocacy Project

Massachusetts
Cape Cod Nursing Home Council
Consumer Advocates for Better Care in the Montachusett Area, Inc.

Michigan
Citizens for Better Care

Minnesota
Nursing Home Residents Advisory Council
Nursing Home Residents Advocates
Nursing Home Ombudsman, Minnesota Board on Aging
Friends and Relatives of Nursing Home Residents

Mississippi
Jackson Gray Panthers

Missouri
Nursing Home Task Force of Kansas City Gray Panthers

New York

Coalition for Institutionalized Aged and Disabled
Village Nursing Home, Caring Community

Ohio

Pro Seniors, Nursing Home Ombudsman Programs, Cincinnatti
Nursing Home Ombudsman Program, Cleveland

Oregon

Benton County Nursing Home Task Force
Gray Panthers of Salem, Nursing Home Task Force
Gray Panthers of Northwest Portland Nursing Home Task Force

Pennsylvania

Coalition of Advocates for the Rights of the Infirm Elderly (CARIE)
Delaware County Legal Assistance Association
Elderly Law Project, NLSA
Interfaith Friends

Rhode Island

RIsource

Tennessee

Social Action Group on Aging

Virginia

Citizens Advisory Council for Camelot Nursing Home
C.O.A.P. (Children of Aging Parents)
Va. Friends & Relatives of Nursing Home Residents
Fairfax Community Action Program
Virginia Gray Panthers, Falls Church
Neighborhood Legal Aid

Washington

Foss Nursing Home Residents' Council
King County Coalition of Nursing Home Resident Councils
Citizens for the Improvement of Nursing Homes

West Virginia

WV Center for Long-Term Care Advocacy
West Virginia Commission on Aging, Nursing Home Ombudsman Program

Wisconsin

Nursing Home Consumers Who Care

Wyoming

Advocates for Better Care/Concerned Citizens for Quality Nursing Home Care

NATIONAL ORGANIZATIONS, AGENCIES, COMMITTEES REGISTERED

ACTION, Older Americans Volunteer Program
ACTION, Retired Senior Volunteer Program
ACTION, Volunteers in Service to America
Administration on Aging, Advocacy Assistance, HHS
AFL-CIO Dept of Community Service
American Association of Homes for the Aging
American Bar Association, Commission on Legal Problems of the Elderly
American College of Nursing Home Administrators
American Health Care Association
American Psychiatric Association
Gerontological Society of America
Gray Panthers
Department of Health and Human Services, General Counsel's Office
Department of Health and Human Services, Health Standards and Quality Bureau
Department of Health and Human Services, HCFA Office of Legislation and Policy
Health Care Financing Administration, Office of Beneficiary Services, (HHS)
Legal Services Corporation
National Association of Area Agencies on Aging
National Citizens Coalition for Nursing Home Reform
National Council on Aging
National Hospice Organization
National Paralegal Institute, Bi-Regional OAA Resource & Support Services Center
National Retired Teachers Association/American Association of Retired Persons
National Senior Citizens Law Center
Nursing Home Information Service, National Council of Senior Citizens
United Presbyterian Church, (Washington Office)
U. S. Senate Special Committee on Aging
White House Conference on Aging

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the 1981
White House
Conference
on
Aging

Report of the Mini-Conference on Legal Services for the Elderly

MCR-22

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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Legal Services For The Elderly

EXECUTIVE SUMMARY

Introduction - Legal services is an essential component of any effective system of delivering social services for three reasons:

- The elderly need legal assistance to protect their rights
- Legal assistance is vital in assuring the access of older Americans to the full range of other social services
- Legal assistance protects the freedom of the individual older person to control his or her own life against the dictates of big government bureaucracy.

Therefore, it is vital to maintain and strengthen the delivery of legal services to the elderly through the Legal Services Corporation, Title IIIB of the Older Americans Act, the private bar, law schools, and the aging network.

The Need - "The elderly" are a group who are present in every family and in every community. Some of them have always been poor; millions of others were middle-class for their working lives and upon retirement find themselves plunged into financial distress. One-fourth of all the elderly are poor and near-poor.

The elderly have unmet legal needs they clearly perceive. There are other needs they don't even recognize because they don't know their rights. The need will increase as more people become elderly, as economic problems continue, and as the elderly become more conscious of their problems. These are human needs, and include people with problems in obtaining the basics of health care, in-home support service, protective services, transportation, income maintenance, consumer security and estate planning.

The facts gathered by experts demonstrate the existence of a major ongoing need for legal services for the elderly. Particular human examples exist in every community in the nation.

Legal services help to empower poor individuals to overcome adverse conditions by protecting their legal rights. By reaffirming that the individual does have rights, legal services particularly promote the individual's self-respect and dignity. Lawyers can help fight government red tape and arbitrary, impersonal bureaucrats. Thus legal services help to limit government and to fight its control of society and the individual. They thus promote the federalist ideal of proper division of responsibility between local and national sectors. The aged themselves dictate what lawyers for the elderly work on. Typical issues involve protecting the right of the frail elderly, securing entitlements of older persons to assistance, or permitting an older person to remain at home with family rather than face placement in an institution.

The aged also want to enjoy the benefits for which they have been paying taxes all their lives. If a senior citizen is unfairly excluded from such benefits, legal assistance may be the necessary means of access to all other vital services. Older people, like other Americans, want to protect their rights and property. Moreover, many are frail, vulnerable, poor, or have limited mobility.

It is particularly important, then, that older persons retain independence, autonomy and dignity rather than receive care passively. Decisions on their lives should be made by the individuals themselves, and by their families. Legal assistance helps further these traditional values by informing older people of their rights, by reminding them that they are not helpless and by assisting them to regain power over their own lives.

Present Programs Are Vital in Meeting These Needs - Clearly, public funding is crucial to adequate legal representation for the elderly. The percentage of older Americans near or below poverty levels, the importance of outreach to them, and the specialized nature of many legal questions facing the elderly, all dictate publicly supported programs as the primary source of representation.

Existing programs which provide legal services for the elderly are effective. Lawyers for the elderly spend 90 percent of their time working with individual clients. When necessary to protect fully the rights of elderly clients, lawyers represent their clients in individual or high-impact lawsuits or through legislative and administrative advocacy. Most legal work does not involve lawsuits, however. It is giving advice, informing older persons of their rights, doing outreach and education, and using basic tools of negotiation.

The legal needs of the elderly can be addressed through a partnership. Publicly-funded legal programs, the private bar, and the wider aging network can efficiently work together. Most work on legal problems of the elderly occurs through programs supported by the Legal Services Corporation (because many of the elderly are poor), through Title IIIB of the Older Americans Act (because legal services provides access to all other services) or through some combination.

Congress' designation of legal services as a priority under the Older Americans Act has left much flexibility and choice to grass-roots decision-makers, yet it has brought a much-needed increase in the provision of legal services to older individuals who need them. A cost-effective partnership exists between the legal workers under the Older Americans Act and the legal workers supported by the Legal Services Corporation.

Legal services for the elderly can be enhanced through innovative ways to promote efficiency. Private lawyers can be involved even more, as through prepaid legal insurance and referral services. Law schools should sensitize future lawyers to the problems of the elderly. Social workers, paraprofessionals, and others can be cost-effective as advocates, allowing lawyers to do the work only they can do. To be efficient, both advocates and the elderly should receive technical assistance and training from experts at the Bi-Regional Support Centers and the National Senior Citizens Law Center.

Advocacy and the Elderly Network - Legal services programs for the elderly are a vital part of the elderly network, working with associations of the elderly, non-lawyer advocates, and other organizations and agencies. Legal services programs enhance the other parts of the network, by helping older individuals, and the network, know their legal rights, legal remedies, and legal skills of negotiation and advocacy.

In turn, the aging network enhances legal services programs by working together on spotting the legal problems of individuals, dealing with some of them through non-lawyer advocates, and doing referrals and community education.

All of these considerations lead this Conference to the following observations, which are set forth in full at the conclusion:

-- Legal services are an integral part of any effective delivery system of social services to the elderly, because they are frequently necessary to meet other basic needs of life.

-- Any government program of general services to the elderly should insure that legal services is an effective component. A framework for a comprehensive legal services delivery system should continue to be incorporated into the Older Americans Act. Effective legal services to the elderly requires the continued involvement of the Legal Services Corporation, other legal services units, the private bar, law schools, para-legals and non-lawyers, and support systems such as those now provided by the Administration on Aging and the Legal Services Corporation.

-- Congress should reauthorize the Older Americans Act, including the priority for legal services, and the Legal Services Corporation Act, at the fullest possible level of funding and without restrictions.

I. LEGAL SERVICES IS AN ESSENTIAL COMPONENT OF ANY EFFECTIVE SOCIAL SERVICES DELIVERY SYSTEM

A. America's Elderly Face Basic Needs Which Are Not Being Met

1. Real People Have Real Needs - Older Americans frequently need legal assistance in order to secure fundamental rights and benefits to which they are entitled. A few examples are illustrative:

-- 81-year old Ms. K was transferred from a nursing home in Connecticut, where she had lived for nearly two years, to a nearby hospital because of "a possible stroke." Later, the physical examination and medical tests performed by the hospital showed no medical conditions requiring hospitalization. Meanwhile, Ms. K, a medicaid recipient, could not regain her room and bed which the nursing home had given to a privately paying resident. She was only able to regain her nursing home bed through a court order after representation by legal services.

-- A second, similar incident happened shortly thereafter at the same home. Another successful suit was filed by a legal services attorney. Subsequent to these two lawsuits, the state of Connecticut enacted legislation requiring nursing homes to reserve beds of residents in acute care hospitals for a certain period of time. The legal services attorney who had litigated the cases at the request of the state assisted in drafting the legislation.

- Mr. and Mrs. R worked their farm in Virginia together for a number of years. After Mr. R had suffered three heart attacks, Mrs. R took over virtually all of the work, including planting, weeding, and harvesting. Mr. R did occasional bookkeeping. The Social Security Administration ruled that Mrs. R was not entitled to receive retirement benefits on her own account because the business was her husband's, not hers. With the assistance of a legal services attorney, Mrs. R successfully argued to the court that the earnings during the years after her husband's disability were hers. She has thus been found eligible to receive Social Security benefits.

- Mr. T, a pensioner, received a letter in his mail stating that he had become a ward of the California county where he resided, and that his monthly pension income would be administered by the Public Guardian of the County. The letter indicated that he had become a public ward under court order, although Mr. T had received no notice of any court proceedings. He contacted a legal services lawyer, who ascertained that Mr. T had not been personally served with notice of the guardianship proceedings; that no evidentiary hearing had occurred; and that the guardianship had been ordered on the basis of a hearsay statement that Mr. T spent part of his monthly pension checks on restaurant meals near his boarding house. Through his attorney Mr. T had the guardianship vacated. Mr. T continued to live independently thereafter, and to enjoy occasional meals in restaurants of his choice.

- A Social Security office in rural Alabama repeatedly failed to provide case reviews to numerous older Americans who had requested them. Delays occurred up to three months in length, all without an explanation from the federal agency. The elderly claimants secured the assistance of a legal advocate who contacted a higher-up in the Social Security office and negotiated immediate and favorable action for his clients.

-- Mrs. A resided in a nursing home in a Western state. Although 94 years old, legally blind, and dependent on a walker, she was mentally alert and very anxious to return to her home. However, her daughter and doctor believed she was not competent to make this decision. Through a neighbor, Mrs. A contacted a law office funded under the Older Americans Act. Through legal counsel Mrs. A regained control of her financial records and belongings and moved into independent quarters.

-- Mr. L went to his local Social Security office in Washington, D.C. to apply for husband benefits on his wife's Social Security account. He told the caseworker to whom he was assigned that he read about a recent Supreme Court decision which said that husbands did not have to be dependent on their wives in order to qualify for husband benefits. The caseworker told him that he was wrong, that Social Security did not go by what newspapers print, and that he was not eligible for husband benefits. When Mr. L returned to Social Security on a friend's advice, he was told by the office supervisor that in fact he was eligible for benefits when he first came to the Social Security office; that the law regarding husband benefits had recently changed; and that he no longer qualified for husband benefits. A legal services office was able to obtain husband benefits for Mr. L after a year-and-a-half and a federal court decision.

-- A local Ombudsman in Maryland learned that there was possible mis-treatment of residents in a boarding home. The Ombudsman met with one resident and determined that his case was serious enough to warrant consulting an attorney. In order to visit five of the residents the attorney had to secure a summons, but upon entering the building found the residents all locked in their rooms. They were rescued from the facility by police and were given lodging in a local community center until they could secure residence in more humane facilities. Meanwhile, the boarding home was closed and the owner was charged with three counts of assault and battery.

2. The Need Is Great and Is Expanding - Every citizen is surrounded by a complex of laws, regulations, agencies, officials, and procedures covering most aspects of a person's life. He or she must deal with it daily. This world of rules confronts the elderly as much as any age group in the United States. It produces overwhelming needs among the elderly which go unmet at several levels.

First, there are immediate and perceived needs which are not being addressed and which require a general expansion of services. Older Americans encounter traditional legal problems similar to those which individuals encounter throughout society. These include such matters as tenancy, home ownership, consumer contracts, vehicle accidents, income tax, and insurance policies. In addition to these traditional cases, however, the elderly confront substantially different and more complex legal problems. Frequently these problems derive from rights which the elderly have earned over a lifetime of work, or rights which derive from explicit Congressional entitlement. Among these are protections against age discrimination and entitlements to Social Security, decent health care in old age, and basic nutrition.

Second, there is an equally large volume of legal needs among the elderly which are not perceived by the elderly as legal in their nature. An older person, for example, may confront pressure to enter a nursing home, because he or she cannot fully provide self care. Although homemaker chore assistance might enable that person to remain in independent living quarters, the availability of homemaker assistance or the steps to secure it may not be known. Thus outreach and educational programs are vitally important in assuring that the elderly are fully informed about all possible solutions to very human and non-legalistic decisions in their lives.

Third, future legal needs among older Americans must be addressed. We are living in a time of limited national resources for the elderly as well as for the general population. The elderly can expect further limits on money and services available to them in crucial areas such as health care, nutrition, and housing. As these services begin to compete among themselves for increasingly scarce resources, legal advocacy rises in importance as a means to secure these services to older individuals. On an abstract level, legal representation may seem less important to the elderly than food, shelter or medicine; on a practical level, however, legal representation is often essential if basics like food, shelter or medicine are going to be available.

The elderly understand their potential to articulate their own interests. They will therefore become aware of additional ways in which law can assist them. The rights of the institutionalized,of persons facing condominium conversion, of those seeking in-home care, of victims of elderly abuse, all reflect a growing consciousness among the elderly of daily problems which may require legal recourse.

3. The Elderly Themselves, and Their Representatives, Recognize the Need for Legal Services - An overwhelming need for legal services still confronts older Americans. In view of this, it is hardly surprising that existing legal advocates for the elderly average over 500 cases yearly, or that 90 percent of this work involves individual case representation. Nonetheless, vast unmet needs continue to pose a major challenge to the entire aging community.

For example, 65 percent of the Area Agencies on Aging (AAAs) report that the need for legal services is relatively important, or is among the most important, of elderly needs. Three out of four state Legal Services Development Specialists believe that the elderly need for legal services is not being met. (Preliminary report prepared for the AoA by the Contract Research Corporation, December, 1980 (CRC Report)).

Equally significant are the responses of leaders of local senior organizations. An overwhelming majority of these leaders (90 percent) agreed that the elderly do have special legal needs. Similarly, 90 percent believe that legal services is most or relatively important among all social services. Most of these leaders (65 percent) indicated that only a part of that need is currently being addressed in their state.

These findings make it clear that legal services is a critical component in the delivery of services to older Americans. While funding of legal services is effective, the need for such services remains greatly unmet. Projects funded under both the Legal Services Corporation and the Older Americans Act continue to lack adequate resources to address properly the needs of an increasing aging population.

B. Legal Assistance Is Vital in Assuring the Access Of Older Americans to the Full Range of Social Services

Major barriers that keep the elderly from obtaining adequate social services are the complexities of the laws and the bureaucracies which deal with those services. Organizations of the elderly know of countless examples of problems that older persons have with red tape, and the indignities they suffer in dealing with bureaucrats. What begins as an older person's modest quest for homemaker help, or for adequate food or for a place to live, all too often ends up as a problem with a rule or the official who decides the rule.

To serve these needs one must understand the laws which govern a service problem; know how to bring the problem to the proper agency; compile the complete and relevant facts about the problem; discuss the problem in a clear and compelling manner, and negotiate. The elderly person requires a representative skilled both in law and in negotiation.

Thus, legal providers are an integral component of the aging service network. Legal advocates can participate in case management with a variety of other service providers; and they can provide an irreplaceable service by assisting elders in their efforts to live independently and with dignity.

Problems of entitlement, procedure, contractual obligation, and simply pushing through the red tape of a bureaucracy, are matters on which legal services can be of great help to the elderly. A legal representative has the skills and knowledge to understand and seek a range of remedies, to secure full access to social services for older Americans.

II. LEGAL SERVICES PROGRAMS, THE PRIVATE BAR AND THE AGING NETWORK TOGETHER OFFER THE POTENTIAL TO ADDRESS THE UNMET LEGAL NEEDS OF THE ELDERLY.

Legal assistance to older Americans turns on a working partnership of legal services programs, the private bar, and the aging network. This partnership is effective and with a proper infusion of additional resources, it can meet the future legal needs of older Americans. Each of these components makes a unique contribution.

Programs funded by the Legal Services Corporation (LSC) and under Title IIIB of the Older Americans Act (OAA) are the most extensive source of professional representation to the elderly. Program lawyers and paralegals are experts, trained in specific substantive areas having the most impact on older Americans and the poor. Services and facilities are widely available to elderly clients and often are delivered through outreach to senior centers, nutrition sites, and other locations frequented by the elderly. The resources permit extended representation of clients in protracted or complex cases, for which the private practitioner may lack resources and the aging network may lack expertise.

Private attorneys can play an important supplemental role in these programs. In addition, they can be important in urban neighborhoods or in rural areas where resources do not allow for a publicly funded office. Private lawyers command a knowledge about wills, probate, and landlord-tenant law which are especially pertinent to the elderly. They often have contacts with elderly individuals through business, church and social organization. A private lawyer can participate usefully in a case as co-counsel with a legal services lawyer when, for example, the former provides procedural and tactical advice to complement the latter's substantive specialty.

The delivery of all legal services in the United States has been changed by the use of non-lawyers. In large law firms serving corporate clients, in government, and in social services thousands of trained non-lawyers now work side by side with lawyers. These people who are directly employed by lawyers are called "paralegals." In addition, there are non-lawyer representatives or community service advisers who are staff members of social services agencies trained to help people with legal problems. They function mainly in the area of government benefit programs, where non-lawyers are specifically permitted to assist and represent clients.

The aging network, with its array of lay advocates, service providers, and senior organizations has more extensive contact with elderly individuals than do legal services programs or the private bar. The aging network provides a unique outreach, providing access to legal assistance not otherwise available to many older Americans. With proper training, network members can identify unperceived legal problems of a client and help that client reach the appropriate service or legal resource.

All segments of the present system of legal assistance delivery have a distinctive role to play in that delivery. The magnitude of unmet need is so great that the real challenge ahead is for these components to develop an even closer working relationship.

A. The Legal Services Corporation Act and Title IIIB of the Older Americans Act Are Key Elements in Providing Legal Services to the Elderly

Congress has provided legal services for the elderly under both the Legal Services Corporation Act and the Older Americans Act. At the local level, almost two-thirds of all Title IIIB OAA legal services providers are LSC projects. Over 40 percent of all LSC projects receive Title IIIB funds. In October of 1979 the median Title IIIB funding for an LSC grantee which reported receipt of such funds was $35,308. The total of Title IIIB funds used for the LSC programs across the nation now approaches $6 million, approximately half the national total reported by State Agencies on Aging as obligated for all kinds of legal advocacy.

There is a growth of expertise by legal services program lawyers in issues of concern to the elderly. There is also growing contact between the legal services and aging communities, evident in the number of joint advocacy activities affecting seniors. Legal services programs have increased non-lawyer advocacy and client involvement in legal services delivery, and in resolving clients' legal problems.

The improvement of legal services for the elderly during the 1970's has been significantly enhanced by the Legal Services Corporation and its extensive network of field programs and state and national support centers. The Corporation's many contributions to legal services advocacy for older people are the result of varied activities and policies.

The dramatic expansion of legal services for poor people throughout the United States has increased the availability of legal services to many elderly persons subsisting on public assistance or fixed retirement incomes. By the end of 1980, all but a few counties across the country contained some element of a legal services program. The formerly isolated and rural elderly have benefitted enormously through the increased availability of legal services.

1. Programs Under the Legal Services Corporation - The Legal Services Corporation Act makes services available to all low-income people without focussing on any particular group. The Act provides for funding of locally controlled programs which set their own priorities based on program resources and total community needs.

In addition, the Legal Services Corporation Act requires that each grantee program, in setting its priorities, consider the legal needs of clients who have special access difficulties or special unmet legal problems. As a result, LSC programs are becoming increasingly available to the elderly. Programs are becoming physically accessible and are performing outreach by going where the clients are located -- to their homes, churches, senior centers, nutrition sites, and nursing homes.

At the national level, a focus of the Legal Services Corporation on elderly concerns, and its growing bond with elderly organizations and with the Administration on Aging, has been fostered by the National Senior Citizens Law Center. NSCLC is one of seventeen national support centers sponsored by the Corporation. Since 1972 NSCLC has offered litigative and advocacy support to LSC and other advocates working for elderly clients in the field. It has represented elderly clients in the areas of medicare, age discrimination, social security and long-term health care. NSCLC maintains an extensive network among legal services programs and senior organizations through its Washington Weekly newsletter and Nursing Home Law Letter, received by 5,000 organizations and individuals working with the elderly.

Other national support centers in areas of health, consumer issues, energy, housing, economic development, and welfare are involved in issues which confront older people. The National Support Centers, LSC Research Institute and LSC Office of Program Support also have actively developed training for LSC field personnel in issues of concern to the elderly. Long term health care and Medicare advocacy recently have been specifically addressed in national training conferences.

In 1977, the Legal Services Corporation and the Administration on Aging began a joint venture to extend legal services for older persons through the cooperation of both LSC and AoA networks at the national and local levels. The Corporation recruited staff who are experts on aging issues and made them available to the Administration on Aging. The LSC/AoA unit has become an important component in the overall development of legal services for older persons. Most important has been its role in stimulating the efficient use of the limited resources of each agency.

Legal workers in LSC programs are experts in the substantive law affecting the social and economic needs of the elderly. They are practiced in the aggressive advocacy required to assure that the rights and benefits of the elderly are protected and expanded. Relationships have been forged with other advocates for the elderly such as long term care ombudsmen, elderly organizations, area agencies, community-based lay advocates and community service advisors. Considerable benefit to the elderly will derive from this grounding in the community.

The role of the Legal Services Corporation and its programs has been integral to the development of vigorous advocacy for older persons. Its continued vitality is critical toward insuring a decent quality of life for older Americans.

2. The Older Americans Act - No federal attention was paid to the legal needs of the elderly until passage of the Older Americans Act in 1965. Under 1973 OAA regulations legal services was one of fourteen different services that could be funded. This language brought no significant OAA funding of legal representation for older Americans, however. Most representation continued to occur through programs funded by the Legal Services Corporation. The need for further legal assistance to the elderly beyond LSC became increasingly apparent. For one thing, about one quarter of all elderly are "near-poor" and live below 125 percent of the poverty level. Many of the elderly have income above legal services eligibility standards, but below levels which can bear the customary fees charged by lawyers in private practice. In addition, the LSC's capacity is strained by limits on its own resources and by competing demands of other needy clients. Finally, several specific barriers to service exist for the elderly including lack of transportation, physical handicaps, fear of crime and difficulty in communication, which require special outreach efforts that add greater costs of service to the aging.

These considerations, coupled with inadequate funding for legal services, caused Congress to amend the OAA in 1975 by making legal services one of four "priority" services. In 1978, Congress again designated legal services to be a priority service under the OAA and in addition specified that at least 50 percent of funds under Title IIIB of the Act must be spent on priority services and that "some funds" must be spent on each priority service, including legal services. Services are provided through each Area Agency on Aging as a recipient of Title IIIB funds.

While the priority is mandatory, it constitutes a minimal directive on the use of funds by an AAA. The priority leaves both the level and the nature of designated services to the discretion of an AAA, and thus encourages variation and creativity in actual funding. Most commonly, a local AAA funds a local legal services program which then establishes a special unit for the elderly, using both AAA and LSC funds. In some areas a separate legal project may be established to serve only the elderly, separately or through a law school, bar association, AAA staff or other social program.

Congress recognized the risk that immediate and visible social services might be funded to the exclusion of legal services whose results are less immediate and visible. Recognizing that legal services are equally as necessary as other services, Congress designated it one of the four priority areas. Congress' foresight has been confirmed; under this statutory priority the number of older Americans who receive legal services today is twice that of three years ago. However, much remains to be done. Half of the AAAs did not have a legal services provider by the summer of 1980. The full framework for delivery of legal services has appeared only recently. Many states had received waivers of their legal services obligations until September 30, 1980; moreover, OAA standards for legal services providers have been in place only since March 31, 1980.

Legal help to the elderly through the Older Americans Act has complemented representation from existing legal services programs and has produced worthwhile results. First, new elderly law programs have come into existence since 1978 which have increased the number of elders who receive vital assistance. Second, area agencies on aging involve older persons in grant-making and thus in priority setting at the local level. Third, LSC resources are simply inadequate, and OAA funding helps already overburdened programs to expand their caseloads to new population segments. A clear correlation exists between OAA funding and the elderly percentage of a program's clientele. Fourth, the LSC "means test" excludes elders who are slightly over income but who are eligible for OAA services. Fifth, OAA assures that special needs of older persons are addressed realistically and creatively, for example, through outreach to senior centers and to non-ambulatory and institutionalized elders. Finally, OAA funding has involved older persons in the development of a system that is attuned to their needs.

The OAA experience, therefore, is a useful model for increasing the level of legal assistance to the elderly. The OAA funding priority has been an important catalyst in causing most AAAs to overcome their earlier detachment from legal services. This detachment originated in a lack of understanding about legal services as a relatively new concept, a distrust of its adversarial dimensions, and the absence of initial contacts with local attorney and staff providers. Today, however, the AAAs increasingly recognize the severity of unmet legal needs among the elderly.

Regulations under the Older Americans Act provide good standards for a provider of legal services (Section 1321.151(c)(2), 45 Fed.Reg. 21,160 (March 31, 1980)). The regulations set minimum elements for effective advocacy and provide an excellent guide to the basic elements of any program of legal assistance to older Americans. These are set out in the Appendix.

3. Title XX - Title XX of the Social Security Act makes federal funds available for disposition by state governments for a wide variety of public services, including legal services. In a few situations Title XX funds have been a source of support for elderly advocacy. However, proponents of legal services face increasing competition from proponents of other social services for limited Title XX funding.

B. The Private Bar Can Play an Active Role in Providing Legal Services for the Elderly

Over 530,000 attorneys practice in the United States, but only a small fraction work for publicly funded programs. Most are engaged in the private practice of law. The private bar is the keystone of the American legal system. Its energies, expertise, and influence are a substantial resource for the elderly population.

Clearly, the private bar is not a resource which ever can become the primary provider of legal representation to older Americans. Far too many older individuals have incomes so moderate that they cannot afford attorney's fees; private lawyers, in turn, are so constrained by business demands that they ordinarily cannot perform more than occasional *pro bono* work. Private attorneys generally lack expertise in complex areas of the law in which the rights of the elderly are typically secured. Much litigation on behalf of the elderly is based on federal statutes, is protracted, and consumes more resources than most private practitioners can afford. The private bar cannot usually provide the kind of outreach needed to surmount the mobility problems of the elderly.

Nonetheless, a potential exists for the private bar to supplement existing programs. Congress recognized this potential in the 1978 Amendments to the Older Americans Act by providing that each Area Agency on Aging "attempt to involve the private bar in legal services activities...including groups within the private bar furnishing services to older individuals on a *pro bono* and reduced fee basis."

The private bar is responding to the legal concerns of older persons, and recognizing its own potential contribution. On a national level in 1978 the American Bar Association created a Commission on Legal Problems of the Elderly, which seeks to stimulate bar association efforts assisting the aged. The ABA Family Law Section, the Section on Real Property, and the Young Lawyers Division all have formed committees on the elderly.

Over 20 state and several local bar associations have committees on the elderly, many of which are actively involved in delivery projects. Four statewide referral systems for the elderly are in operation, as well as state preventive law community education projects for senior citizens. Over a dozen states have sought to enhance the knowledge of bar members by providing continuing legal education sessions on law and aging. Almost 60 local bar projects currently operating or shortly to begin involve volunteer private lawyers, low-fee referral systems, and community education.

However, private bar efforts fall far short of the need among older Americans for legal help. Private attorneys often fail to perceive the many incentives for their fuller participation in elderly representation. Aging advocates should advertise these incentives, including the private attorneys' self-interest in generating goodwill and fee-generating cases; the opportunity to participate in trials and administrative hearing by attorneys who do not do so in their regular practice; and the chance to get substantive training in new areas of law. A means test might assure that older Americans with the greatest economic need will be served. In addition, private bar efforts should be integrated into the totality of legal services delivery in order to use private attorney expertise most economically, e.g., handling wills, estate planning, auto accidents and family law.

Private practitioners and bar associations should expand their role in providing legal resources for the aged by (1) initiating and actively participating in projects to stimulate efforts by the private bar to deliver legal services to the elderly; (2) supporting publicly funded legal service programs for the elderly; and (3) working cooperatively with existing public programs.

1. Initiating and Participating in Projects for the Elderly - In the CRC Report discussed above, 85 percent of private bar leaders agreed that the elderly have special legal needs; 89 percent agreed that legal services are an important component of social services for the elderly. The organized private bar must be encouraged to act on this consensus.

The ABA House of Delegates, for instance, in 1975 resolved that it is "the basic responsibility of each lawyer engaged in the practice of law to provide public interest legal services... without fee or at a substantially reduced fee..." Many attorneys can fulfill this responsibility to the elderly by participating in a *pro bono* project or reduced fee referral system for the elderly; by giving preventive law educational presentations and law day programs for senior citizens; by volunteering with legal service for the elderly projects; or by pushing for legislative reforms affecting the elderly.

In 1980, the ABA House of Delegates passed a resolution urging lawyer referral services to increase their efforts to reach older persons. Over 320 referral services exist nationwide. These service facilities must be encouraged to increase their outreach to places where the senior citizens live and gather, and to provide training for attorneys interested in serving aged clients. Participating attorneys must be encouraged to visit senior centers, for example, and to provide fee adjustments and *pro bono* services for the elderly of moderate means. The efforts of the private bar must be motivated. They must be coordinated. And there should be quality control, and provision of backup and technical assistance. Law schools are well suited to enhance private lawyer assistance to the elderly. Law schools must recognize law and aging as an important new field of law, and offer courses to train future lawyers in this field.

2. Supporting Public Legal Service Programs - Private bar efforts to meet the legal needs of the elderly must be accompanied by vigorous support of the public legal service network. This support has historically been forthcoming from the American Bar Association. In 1965, the ABA resolved to "cooperate with the Office of Economic Opportunity and other appropriate groups in the development and implementation of programs for expanding availability of legal services to indigents and persons of low income..." In 1973 the ABA reaffirmed its support for expansion of legal service efforts and for the establishment of the Legal Services Corporation.

The aging network provides an ideal medium through which the ABA's leadership in supporting legal services can be carried to state and local levels. Private lawyers should familiarize themselves with the aging network, support its funding, and contribute their skills and resources to the operation of its programs.

3. Working Cooperatively with Public Legal Programs - The private bar must not only voice support for public programs of legal representation for older persons, but must also work cooperatively with them. Indeed, the best system of legal resources for the elderly will come from their combined efforts.

For instance, in Washington, D.C. a roster of private attorneys and firms serve the elderly through a publicly funded and staffed pro bono program. In Oregon, the needs of local elderly are matched with willing attorneys through pro bono coordinators whose work is made possible because several agencies on aging have made money available to legal aid programs to hire them. In San Francisco, volunteer attorneys work together with staff attorneys to expand service at senior centers.

In many localities, legal service attorneys refer elderly persons needing simple wills to a panel of private attorneys on a pro bono or low fee basis. In some cities, law firms are matched with legal service for the elderly programs to facilitate an exchange of litigation skills and specialized knowledge. Such imaginative, cooperative programs must be expanded and replicated throughout the country to produce adequate legal services for the growing aged population.

C. The Aging Network Plays a Vital Role In Legal Services to the Elderly

Older people have legal problems not shared by other groups, and they are peculiarly vulnerable and isolated. This makes the case compelling for a separate statutory framework, given the unique interplay between the aging network and legal services for the elderly. The Older Americans Act establishes a network from the grass-roots up to the federal level and anticipates that all parts of it will create leverage on other services benefiting the elderly.

The term "network" is used with two meanings. One refers to the official network created by the Older Americans Act: AoA in Washington, Regional Offices of AoA, State Units on Aging, Area Agencies on Aging, and the various projects funded through this system. A broader definition of "network" includes all organizations interested in the needs of elderly people such as church groups, tenant groups, social clubs, retirement groups, and national organizations. The aging network inclusive of both definitions always has seen itself as an advocate for the rights of older people.

LSC programs and Title III programs have a vital role to play in the traditional legal representation of an individual, but do so as a complement of lawyers and non-lawyers working with the network to engage in a whole spectrum of activity.

One purpose of legal services and advocacy for older people is to enhance the capacity of people to utilize their own knowledge and skills to obtain legal rights and remedies. Thus part of the goal of legal services to the elderly is to expand the number of people with legal knowledge and skills, so that individuals and groups will be able to assert themselves effectively in a variety of forums on a wide range of issues. Elderly people, and indeed any people who are isolated, physically impaired, or reliant on others may succumb to a passive dependency which makes them vulnerable to exploitation or neglect. Informing older people of their legal rights and how to assert them, assisting them as groups, and coordinating legal and social services, allows legal services to help older people gain the confidence and skills needed to address their own legal and social problems. Lawyers, paralegals and advocates can explain the law, help draft documents, advise on government structures, and suggest courses of action. Through this approach legal services activity assists older people to achieve their own goals, and becomes a constituent part of the elderly network.

The elderly network is inter-connected. Planning, coordination and funding are linked from the grass-roots community groups through the area agencies and state agencies to AoA. Legal services operates as one element of this system and is thus an integral and essential part of the network. Conversely, the network affects the legal rights of older people.

Opportunity arises for innovation in the delivery of legal representation to the elderly. A need exists to educate older people about their rights, and to sensitize law students and others to the legal needs of the elderly. Most important is the potential use of paraprofessionals, social workers and others to make the process more efficient.

Training is vital in this preparation. Those dealing with housing need to understand the Energy Assistance laws and weatherization program laws. Those who question whether a state agency is in compliance with federal law in administering a program must know the law, available remedies, and techniques for obtaining rights. Those dealing with nursing home patients should understand the laws governing patients' rights, access to facilities, and rules for medicaid providers. Persons who address long-term care problems need an understanding of state guardianship and commitment laws, and, as well, should have the capacity to counsel older persons on eligibility for SSI, food stamps, Medicaid, and tax benefits.

AoA has funded five Bi-Regional Support Centers for Legal Services and Long-Term Care Advocacy. These Centers work with state and area agencies, with the aging network, and with component parts of the legal services community such as the private bar, Legal Services Corporation, and law schools. Their mission is to give training in law and advocacy, to help the states set up training programs to link lawyers with non-lawyers and agencies, and to provide technical assistance.

Many problems of the elderly can be alleviated if the elderly develop a capacity to understand and utilize the myriad laws which affect them. The premise of the current legal services effort is that individual clients will receive needed legal advice and representation, and that the entire network will have knowledge of appropriate laws, remedies, and advocacy techniques.

CONCLUSION

The provision of legal services is a critical component of any long term system which addresses the needs of older Americans. This provision is absolutely essential if that system is to be comprehensive in its effect, coordinated in its support of other services, and community-based in its work. Legal assistance to older individuals is an important social service in itself. It is equally important in securing all of the other services necessary to a life of dignity and independence.

Legal assistance to the elderly may serve older people, but is a new program itself. This program deserves firm support at the national level, and deserves freedom from tinkering during this important stage in development. An unequivocal national commitment is needed, therefore, which encompasses certain essential efforts on behalf of America's elderly. These efforts are contained in specific recommendations passed by this Conference:

1. Legal services are integral to vindicating the rights of older persons, and to the delivery of social services to the elderly.

2. In order to assure the effective provision of legal services to the elderly, existing efforts must be maintained, and new efforts initiated, with the goal of achieving a full range of legal services to the elderly.

3. Effective legal services to the elderly requires the continued involvement of lawyers, the Legal Services Corporation, other legal services units, the private bar, law schools, paralegals and non-lawyers, and support systems such as those now provided by the Administration on Aging and the Legal Services Corporation. A framework for this comprehensive legal services delivery system should continue to be incorporated into the Older Americans Act.

4. Because constitutional and legal rights are fundamental rights of all citizens, and because the exercise of such rights is frequently necessary to meet other basic needs of life, the Older Americans Act and any similar government program of general services to the elderly should include specialized legal services as an essential component.

5. Congress should reauthorize the Older Americans Act, including the priority for legal services, and the Legal Services Corporation Act, both at the fullest possible level of funding and without restrictions on the availability of legal representation for older Americans.

APPENDIX

Grants for State and Community Programs on Aging

45 Fed.Reg. 21,160 (March 31, 1980) (to be codified in 45 C.F.R. 1321.151)

45 C.F.R. 1321.151(c) (Conditions legal services providers must meet)

. . . .

(2) The area agency must award funds to the legal services provider(s) that most fully meet(s) the following standards. The legal services provider(s) -

(i) Has staff with expertise in specific areas of law affecting older persons in economic or social need; for example, public benefits, institutionalization and alternatives to institutionalization;

(ii)Demonstrates the capacity to provide effective administrative and judicial representation in the areas of law affecting older persons with social or economic need;

(iii) Demonstrates the capacity to provide support to other advocacy efforts, for example, the long-term care ombudsman program;

(iv) Demonstrates the capacity to effectively deliver legal services to institutionalized, isolated, and homebound individuals;

(v) Has offices and/or outreach sites which are convenient and accessible to older persons in the community;

(vi) Demonstrates the capacity to provide legal services in a cost effective manner; and

(vii) Demonstrates the capacity to obtain other resources to provide legal services to older persons.

NSCLC WHITE HOUSE MINI-CONFERENCE ON LEGAL SERVICES FOR THE ELDERLY

January 29-30, 1981
Washington, D.C.

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the 1981
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on
Aging

Report of the Mini-Conference on the Inter-relationship of Government, Private Foundations, Corporate Grant-Makers and Unions

MCR-23

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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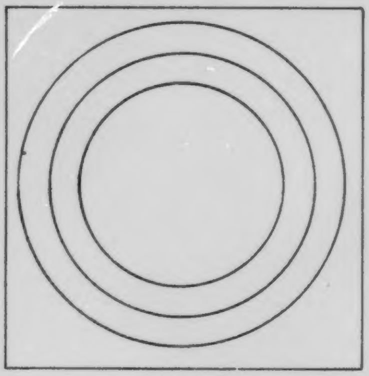

The Interrelationship of Government, Private Foundations, Corporate Grantmakers and Unions

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January 15-16, 1981 New York, New York

A White House Conference on Aging Official Mini-Conference

Program

● **Thursday, January 15, 1981**

1:30-2:30 p.m.
Registration
Auditorium
Hunter College School of Social Work
129 East 79th Street
(off Lexington Avenue)

2:30-2:45 p.m.
Introduction and Welcome
Jacqueline Wexler, Chairperson, Board of Overseers, Brookdale Center on Aging

2:45-5:15 p.m.
General Session

2:45-3:15 p.m.
Speaker
John G. Simon, Director, Program on Non-Profit Organizations and Augustus Lines Professor of Law, Yale University; President, Taconic Foundation; Co-author: *The Ethical Investor*

Topic
"Current Funding Dilemmas of the Independent Sector"

3:15-5:15 p.m.
Response by panelists/ general discussion
Chairperson
James Dumpson, Assistant Director, New York Community Trust

Panelists
Bertram Beck, General Director, Community Service Society

Barbara Blum, Commissioner, New York State Department of Social Services

Hector Hill, Consumer Representative, Jamaica Service Program for Older Adults

Bert Seidman, Director, Department of Social Security, AFL-CIO

Samuel Silberman, President, Gulf + Western Foundation

5:15 p.m.
Conference Recessed

6:30-7:15 p.m.
Cocktail Reception

7:15 p.m.
Dinner
Reception and dinner at the Harmonie Club
4 East 60th Street
Hosts for the reception and dinner —Mr. & Mrs. Arthur Garson

Presiding
Donna Shalala, President, Hunter College

Remarks
James P. Murphy, Chairman, Board of Trustees, City University of New York; Executive Vice President, New York State Bankers Association

Arthur Garson, Brookdale Center on Aging, Board of Overseers

Hon. Edward I. Koch, Mayor of the City of New York

Speaker
Jerome Waldie, Executive Director, White House Conference on Aging

● **Friday, January 16, 1981**
1211 Avenue of the Americas
Chase Manhattan Bank, N.A.

8:30-9:30 a.m.
Continental Breakfast
Executive Dining Room (36th Floor)

Film
"It's Only A Matter of Time," produced by Over Easy, the national daily PBS network television series

9:30-10:00 a.m.
Presiding
Edgar Coster, Vice President, Trust Department, Chase Manhattan Bank, N.A.

Speaker
Hon. William S. Cohen (R.-Maine), U.S. Senate; Member, Senate Special Committee on Aging

10:00-12:30 p.m.
Concurrent Roundtables
I. The Older Worker

Speaker
Harold Sheppard, the President's Counsellor On Aging, Senior Author: *The Greying Of Working America, The Job Hunt*

Commentator
Barbara Reuter, Manager, Consumer Affairs and Corporate Support Programs, Philip Morris Inc.

Chairpersons

Ira Hirschfield, Director of Contributions, Levi Strauss Foundation

Jerry N. Clark, Director of Research, United Mine Workers of America Health and Retirement Funds

Lou Glasse, Commissioner, New York State Office for the Aging

II. Health Care

Speaker

Roger Egeberg, M.D., Director, Office of Professional and Scientific Affairs, Health Care Financing Administration, U.S. Department of Health and Human Services

Commentator

Monroe E. Trout, M.D., Senior Vice President for Medical and Scientific Affairs, Sterling Drug Inc.

Chairpersons

Bayard Dominick, President, New Canaan Community Foundation

Peggy Tishman, Chairperson, Committee on Aging, Federation of Jewish Philanthropies

III. Education, Leisure and Continuing Opportunities in Later Life

Speaker

Jack Ossofsky, Executive Director, National Council on Aging, Inc.

Commentator

Kathleen Selz, Special Assistant to the Deputy Undersecretary for Intergovernmental Affairs, U.S. Department of Health and Human Services

Chairpersons

Joyce Austin, Executive Vice President, Federation of Protestant Welfare Agencies

Jen C. Mooney, Member, Communications Council, American Bankers Association; Vice President, First Alabama Bank of Montgomery, N.A.; Author: *Let's Talk About Money, A Widow's Guide and Checklist*

IV. Physical and Social Environment

Speaker

Raymond J. Struyk, Senior Research Associate, The Urban Institute, former Deputy Assistant Secretary for Policy, Development and Research, U.S. Department of Housing and Urban Development; Co-author: *Improving the Elderly's Housing*

Commentator

Most Reverend Joseph M. Sullivan, D.D.

Chairpersons

Anna V. Brown, Executive Director, The Mayor's Commission on Aging, Cleveland, Ohio

Janet Sainer, Commissioner, New York City Department for the Aging

12:30-2:00 p.m.
Luncheon

Hosts for the luncheon—the Chase Manhattan Bank, N.A.

Presiding

Jacqueline Wexler, Chairperson, Board of Overseers, Brookdale Center on Aging

Speaker

Hon. Bill Green (R.-New York), House of Representatives; Member, House Select Committee on Aging

2:30-4:45 p.m.
Plenary Session
Chairperson

Gregory Farrell, Executive Director Fund for the City of New York

2:30-3:10 p.m.
Commentators' Reports

3:10-4:45 p.m.
Formulation of recommendations for policy and legislation for White House Conference on Aging

4:45 p.m.
Conference adjourns

4:45-5:30 p.m.
Wine and Cheese Reception

NEW DIRECTIONS IN FUNDING AND PROGRAM PRIORITIES FOR THE AGING

"I...will propose budget cuts in virtually every department of government..."

President Ronald Reagan, February 5, 1981

How should the United States pay for programs for the aging? Which programs should be funded by the government? Which programs are best paid for - and run - by privately-sponsored organizations? Can foundations and other organizations providing funding and/or services maintain their autonomy if they themselves are dependent upon the government for some of their funding? Should foundations and the business community assume a larger share of responsibility for the funding of services for our aging population?

A White House Conference on Aging Mini-Conference attended by more than 100 government officials, legislators, foundation executives and representatives from corporate and corporate-sponsored foundations, labor unions and service organizations was convened to examine these and other questions. Held in New York City on January 15-16, the week before the inauguration, the larger issue of the appropriate role of the federal government became an integral part of the Conference deliberations. Three basic areas of consensus emerged. The participants agreed that:

0 There is a public (government) responsibility for the common welfare of our aged citizens, for guaranteeing at least the floor of income security, housing and health care.

0 Better communication and working relationships among representatives of business, labor, the government, and private philanthropy* is a necessity.

Professor John G. Simon, Director of The Program on Non-Profit Organizations and Augustus Lines Professor of Law at Yale University, spoke at the opening session of the five dilemmas he saw confronting the private sector. A theme of his discussion of the five - mission, funding, power, effectiveness, and governance - was of the inter-connectedness of the sectors. Other speakers, each representing a different sector with a particular , special perspective, also addressed the public-private relationship.

From the vantage point of government, Barbara Blum, Commissioner of the New York State Department of Social Services, explained the problems of public officials. Caught up in the day-to-day management of complex programs they are often deprived of the opportunity to think about the larger picture or the long-range goals which should inform the decision-making process. She saw the private sector as playing an important role in goal formulation and controversy resolution. Commissioner Blum urged the conference participants to find ways to encourage a continuing dialogue between representatives of the public and private sectors.

Hector Hill, a board member of The Jamaica Service Program for Older Adults (JASPOA) spoke about the impact of the uncertainty of funding on this service program; about the problems the agency - and the community - faced when JASPOA was forced to discontinue services which had been funded as time-limited demonstration programs - despite the fact that the need for and effectiveness of these programs had been demonstrated. The most talented staff and board members, said Hill, are forced to spend increasing amounts of time on fundraising activities - at the expense of their active, involved participation in program development and service delivery. Is it not possible that better communication and collaboration among the various units of government, among foundations, and between government and foundations will lead to more secure funding of programs which have proved their merit?

* An interesting difference which emerged in the opening session had to do with the definition of the sectors. Professor John Simon, who keynoted the conference, argued that three sectors - the government, corporations, and private philanthropic foundations - provide the organized support for social provisions in the United States. Samuel Silberman, president of the Gulf + Western Foundation (corporate) and The Lois & Samuel Silberman Fund, a voluntary foundation, spoke of only two sectors - the public-government sector, and the private, which includes corporations, unions, and voluntary foundations.

Dr. James Dumpson, Assistant Director of the New York Community Trust, who chaired the opening session, and the Most Reverend Joseph M. Sullivan, D.D., Executive Vice President of the Board of Trustees of Catholic Charities of Brooklyn, who served as a commentator for one of the Roundtables, were among those who spoke to this need for better communication among the sectors. At the least, it was agreed, foundations and corporate grant makers need to know the direction and priorities of government agencies in order to make their own funding decisions more effective.

Various mechanisms for inter-sector communication and collaboration were suggested. Anna V. Brown, Executive Director of The Mayor's Commission on Aging, in Cleveland, Ohio, reported on the informal cooperative arrangement between the Commission, the official Area Agency on Aging, and The Cleveland Foundation. Funding priorities are jointly considered, thus assuring careful attention to gaps and fragmentation of services. This process also minimizes the likelihood of duplicative effort or funding of ineffective programs. Byron Gold, Special Assistant to the Commissioner on Aging (AoA), stressed the particular value of meetings, like the Mini-Conference, which provide opportunities for face-to-face discussion.

There was concern that the autonomy and capacity for innovation and the ability to address special needs which have characterized the private sector not be jeopardized in the process of achieving improved linkage between the public and private sectors. The dangers of collaboration were recognized, but in the end, the consensus was that this Mini-White House Conference represented a prototype of one useful vehicle of communication and cooperation. The hope was that the White House Conference will include in its final recommendations a plan for continuous opportunities for exchange among the sectors.

One critical area of difference emerged during the Conference concerning the level and nature of government funding. There was no resolution of this issue. But it was recognized as an issue which merits careful attentnion by all citizens concerned about the situation of older people in the United States.

The call for increased activity by foundations, corporations and unions in the field of aging must not obscure or distort this public responsibility: "We must not," said Bert Seidman, Director of the Department of Social Security for the AFL-CIO, "ignore the history of the struggle in the United States to achieve federal responsibility for health and welfare programs, nor can we assume that the fight for these programs is over."

One essential point made in support of this assumption: "The difference in scale" cannot be ignored. Only the federal government has the resources necessary for funding income maintenance, health care, and housing programs. The hope of some that private and corporate philanthropy can "pick up the slack" that would be created by massive cuts in public funding ignores this difference in the scale of the resources at the command of the public and private sectors.

0 The private sector is important both as a source of funds and as the auspice for provision of services in the field of aging. Gregory Farrell, Executive Director, Fund for the City of New York, who chaired the final plenary session of the Conference, articulated a conclusion reached by many conference participants: The list of priorities in the field of aging is a long one, the case made for increases and improvements in the field, and the evidence of gaps in the health and social service networks were persuasive. The conclusion therefore that programs on behalf of older people require allocation from all sections of our society was inescapable. Yet, with some notable exceptions, corporations and foundations have not assigned high priority to these programs. For example, Internal Revenue Service regulations permit corporations to take philanthropic deductions of up to five per cent of net income before taxes, but the average corporate philanthropic contribution represents slightly less than one per cent of annual income before taxes.

Nor have many foundations taken on the innovative role that is usually ascribed to them. In a recent issue of Grants Magazine (September 1980) distributed to Conference participants, Harriet L. Warm, Executive Director of the Florence V. Burden Foundation, a Conference sponsor, analyzed "Foundation Grantmaking for the Elderly." Warm found that while foundations had indeed made grants to the elderly, "roughly equivalent to those made for children and the handicapped, foundation support for the elderly appeared to be "unstable," with "a relatively small number of foundations being active" in this field on a regular basis. She also found that fully 80 per cent of foundation support for the aging consists in supporting existing programs rather than in funding "programs that introduced new kinds of solutions or contributed to changes in current aging policies."

Bill Green (R. - N.Y.), a member of the House Select Committee on Aging, said that in view of the expectation that federal resources for aging services will not be increased, priority must be assigned to programs targeted to the oldest, most infirm or ill, to the most disadvantaged members of the aged cohort. While acknowledging the importance of educational, socialization and other programs designed for the "young-old," the healthier, the better-off among the aged, he explained his belief that the urgency of the needs of the poor and sick, in combination with reduced resources, require that the "soft" services for the better-off be funded from private sources -- the consumers of these services themselves and/or foundations and corporations.

Dr. Roger Egeberg, Director of the Office of Professional and Scientific Affairs of the Health Care Financing Administration (HHS) and Jack Ossofsky, Executive Director of the National Council on Aging, Inc. presented arguments that ran counter to Rep. Green's position. In Dr. Egeberg's paper on Health Care priorities, he emphasized the need for more federal funding of what he called "preventive maintenance" programs. He pointed out that at least some of the incapacity and impairment which characterizes Long-Term Care Facility patients could be prevented by a range of social and medical programs. Clearly, the targeting Rep. Green called for is incompatible with Dr. Egeberg's emphasis on preventive programs.

The Ossofsky argument rested on somewhat different grounds: Educational, socialization, voluntary services programs are important because they promote mental and physical health. But they have, in addition, an intrinsic importance, and are a necessary part of the quality of life of the participants and the broader community. They warrant, therefore, inclusion in "the floor" of service and programs to which older people are entitled and for which there is a public, as well as private, responsibility.

The Conference ended with a formulation of a list of programs which the conferees believe merit public support. Included are programs which would meet Rep. Green's call for the targeting of funds to the most disadvantaged and also other programs which qualify, in Dr. Egeberg's terms, as preventive programs or in Ossofsky's view, as essential to the quality of individual and communal life.

Given President Reagan's emphasis in his State of the Union address on February 5th, on limiting the Federal government's responsibility to the "truly needy," it seems clear that this issue of the scope of the Federal government's activities in the field of aging will be one of great moment in the decade of the 80s.

PROGRAM PRIORITY RECOMMENDATIONS

The conferees:

0 Called for increased attention to employment opportunities for older workers. They suggested that experimentation with such strategies as flex-time, job sharing and re-training, for example, would provide a fruitful area for private and corporate foundations.

0 Took account of the fact that a higher percentage (75%) of older people vote than do other age groups. They recommended support for efforts to maximize the political participation and effectiveness of these voters.

0 Endorsed the suggestion made by Senator William S. Cohen (R. - Maine) that funds be provided for the creation of a network of "One-Stop Information and Referral Centers" in order to insure the accessibility of needed services.

0 Called for increased emphasis on self-help and mutual aid groups among older people.

0 Suggested further testing of the use of strategies like "reverse annuities" designed to help older people maintain themselves in their own homes.

0 Suggested that housing strategies also take account of the importance of older people as sources of stability in "fragile" neighborhoods. They noted that housing assistance programs could be designed so as to serve both individual needs and the goal of neighborhood preservation.

0 Recommended increased funding of home health care programs to provide critically needed services to functionally disabled or chronically ill older people in the community.

ORGANIZATIONAL RECOMMENDATIONS

The conferees:

0 Recognized that older people and service agencies alike are often caught in a maze of complex regulations which become an obstacle to effective service provision and utilization. They called for thorough-going review and streamlining of these regulations.

0 Called for integration and coordination of public programs which now are located at all three levels of government and in a number of different agencies.

- Urged that all funding agencies - regardless of sector- recognize that service and educational institutions sorely need funding for administrative staff as well as for their program activities.

- Recognized that older people constitute, in the words of Jack Ossofsky, "a new leisured class," and urged support for a range of programs which would reflect the diversity of the age group and give people the opportunity to choose the way(s) they use this leisure.

- Asked for exploration of new ways to compensate older people for their participation in service activities, including the possibility of income deductions for hours of service, similar to deductions for monetary charitable deductions.

- Urged that voluntary and corporate foundations increase their activities in the field of aging - both in the determination of priorities and in the funding of programs.

OTHER RECOMMENDATIONS

Some recommendations were made that do not fit comfortably under the rubric of Program or Organization. These have to do with those attitudes and beliefs which the conference participants agreed must permeate the work of all who care about the situation of older people in the United States. These recommendations -- targeted as priorities for the 80s -- include:

- An all-out attack on ageism. Ageism,a stereotyping, denigrating attitude toward older people is the root cause of many of the myths and misperceptions that surround aging in our society; it leads to the systematic exclusion of the old from the mainstream of American life.

- The development of clearly articulated public values and individual ethics to guide those working in the field of aging. The conferees responded to Senator Cohen's reminder that Mother Teresa teaches that "welfare is for a purpose and love is for a person" as well as Dr. Egeberg's call for programs and people who articulate real concern for people and who demonstrate this concern through humane and sensitive care. Our work in priority determination, program design and evaluation, the search for funds and for mechanisms of collaboration and coordination, must, the conferees agreed, be informed and suffused by attitudes of caring and compassion.

CONCLUSION

The conferees stressed the importance of citizen involvement in the process of policy analysis and in the determination of priorities -- as embodied in the White House Conference itself. Jerome Waldie, the Executive Director of the White House Conference on Aging, described the process by which thousands of Americans of all ages have been engaged in mini-White House Conferences. And their recommendations will become part of the deliberations of the Conference. The conferees strongly endorsed these efforts to insure that the White House Conference reflects the diversity of our population and provides maximum opportunity for citizen participation during every phase of the conference process-including the formulation of the final set of recommendations the White House Conference on Aging will make to the nation.

"Our spending cuts will not be at the expense of the truly needy...We can, with compassion, continue to meet our responsibility to those who through no fault of their own need our help..."

President Ronald Reagan, February 5, 1981

Participants

Carlos Alvarez - Federation of Protestant Welfare Agencies
Joyce Austin - Federation of Protestant Welfare Agencies
Clealand Baker - Burroughs Wellcome Co.
Bertram Beck - Community Service Society
Robert Benedict - Administration on Aging
Alice Berkowitz - Veterans Administration
Henry Beukema - Howard Heinz Endowment
Hon. Barbara Blum - New York State Department of Social Services
Rachel Boaz - Hunter College
Doris Bressler - Metropolitan Life Insurance Company
Hon. Anna V. Brown - Mayor's Commission on Aging, Cleveland, Ohio

Richard Brodie - Mayor's Office for the Handicapped Advisory Council, N.Y.C.
Irving Brodsky - Associated YM & WHAs
Ellen Camerieri - Catholic Charities of the Archdiocese of New York
Nancy Castleman - Fund for the City of New York
Thomas Chalmers, M.D. - Mt. Sinai School of Medicine
Jerry Clark - United Mine Workers of America Health and Retirement Fund
Hon. William S. Cohen - United States Senate
Irene Cook - Brookdale Center on Aging
Norris Lee Cook - United Way of New York State
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Diana de Pugh - Amalgamated Clothing & Textile Workers Union
Darlene Despres - Chase Manhattan Bank, N.A.
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Rose Dobrof - Brookdale Center on Aging
Bayard Dominick - New Canaan Community Foundation
Harvey Dreyer - Chalek & Dreyer
James Dumpson - New York Community Trust
Thomas Dyett - Isaac H. Tuttle Fund (formerly HOMAC)
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Msgr. Charles Fahey - Federal Council on Aging
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Arthur Garson - Brookdale Center on Aging
Bunny Garson - Brookdale Center on Aging
Linda Gillies - Vincent Astor Foundation
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Lou Glasse - New York State Office for the Aging
Byron Gold - Administration on Aging
Harriet Gorlin - Brookdale Center on Aging
Jane Gould - New York State Office for the Aging
Hon. Bill Green - United States House of Representatives
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Arthur Gruen - Hunter College
Grace Hanks - KQED, Inc. ("Over Easy")
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Marilyn Hennessy -The Retirement Research Foundation
Hector Hill - Consumer representative
Amy Horowitz - Brookdale Center on Aging
Teresa Hughes - Actress
Kenneth Jablon - Chase Manhattan Bank, N.A.
Martha Johns - Jamaica Service Program for Older Adults
Geneva Johnson - United Way of America
Thomas B. Jones - Merrill Lynch
Loren F. Kahle, Jr. - Exxon Corporation
Marc Kaminsky - Writers & Teachers Collaborative
Alvin Kabot - Hunter College
Ann Kellman - Consumer representative
Hon. Edward I. Koch - Mayor, City of New York
Naomi Kroeger - Hunter College
Paul Kurzman - Hunter College
Frederick Lane - Baruch College
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Preston Lewis - Greater Harlem Nursing Home
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Mindy Ossofsky - Andrew Freeman Home
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Molly Parkinson - Brookdale Center on Aging
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Phyllis Quan - The Atlantic Richfield Foundation
Barbara Reuter - Philip Morris Inc.
Carol Reuter - New York Life Insurance Company
Carol Robinson - Isaac H. Tuttle Fund (formerly HOMAC)
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Rev. William Scar - Lutheran Social Services
Jerome Schneewind - Hunter College
Harris Schrank - Equitable Life Assurance Society of the United States
Bert Seidman - Department of Social Security (AFL-CIO)
Kathleen Selz - United States Deparment of Health and Human Services

Donna Shalala - Hunter College
Harold Sheppard - The White House
Roger Sherman - Brookdale Center on Aging
Lois Silberman - Lois and Samuel Silberman Fund
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Donald A. Snider - New York State Department of Social Services
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Raymond Struyk - The Urban Institute
Mary Sughrue - Medicaid Fraud Conrol Unit, New York State
Henry Suhrke - Philanthropy Monthly
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Peggy Tishman - Federation of Jewish Philanthropies
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Mitchell Waife - Jewish Home and Hospital for the Aged
Harriet Warm - Burden Foundation
Jacqueline Wexler - Brookdale Center on Aging
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Virginia White - Grants Magazine
Catherine Willis - Chase Manhattan Bank, N.A.
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Lucille Wolf - Consumer representative
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Rose Dobrof, *Director, Brookdale Center on Aging*
Jean T. Sadowsky, *Conference Director*

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the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on the American Indian/Alaskan Native Elderly

MCR-24

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

INDIAN ELDERLY

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September 8-10, 1980

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1981 WHITE HOUSE CONFERENCE ON AGING
TECHNICAL REPORT ON THE AMERICAN INDIAN/ ALASKAN NATIVE ELDERLY

prepared by the

NATIONAL INDIAN COUNCIL ON AGING

This report presents the findings and consensus of the 1980 National Indian Conference on Aging, sponsored by the National Indian Council on Aging, September 8-10, 1980 in Albuquerque, New Mexico.

The conference, designated as a White House Mini-Conference on Aging, drew 1,165 participants from reservations, rural areas and cities across the country. Almost exactly half of the participants were Indian or Alaskan Native* people 60 years of age or older. Other participants included service providers, administrators, policy makers, researchers, and representatives of federal, state and local programs for Indians or the elderly. In all, approximately 140 tribes were represented.

During the three days of the conference, participants met in 25 intensive workshops which addressed various aspects of the six major WHCOA subjects: economic security, physical and mental health, social well-being, research, older Americans as a national resource, and creating an age-integrated society.

In these workshops, participants identified current and long-range needs, made literally hundreds of recommendations, and developed 45 formal resolutions.

This report will provide an overview of the current status of Indian elderly, and will discuss the major recommendations made by conference participants. Emphasis will be on a small number of basic themes that recurred throughout the conference proceedings. (A full report on the conference, including all recommendations and resolutions, is available from the National Indian Council on Aging.)

BACKGROUND

The Indian/Alaskan Native population is small, but diverse. According to the 1970 Census, the population is estimated at about 1 million, with 83,000 over 60 years of age. About 400 different tribes exist in the U.S. today, speaking over 250 distinct languages. Currently, there are close to 600 reservations, rancherias, and Alaskan Native villages.

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* Throughout this report, the term "Indian" includes reference to Alaskan Natives.

each with its own government. These reservations range in size from less than one acre to 14 million acres. Nearly half the Indian elderly population live on reservations, with the remainder in urban or non-reservation rural areas.

The following six sections are intended to provide background on the elderly of this population.

ECONOMIC SECURITY

The economic status of the Indian elderly is even less "secure" than that of most older Americans. In 1970, the median income level for elderly Indian men was $1,554 - significantly below the poverty level. For women, the figure was even lower - $1,162. The 1980 Census data is not expected to change this picture significantly.

What if the elderly would like to work? Unemployment rates among the Indian community indicate that Indian people have difficulty finding jobs and therefore wages. In 1970, the median income level for Indians on reservations was approximately $1,500 per year. Unemployment on reservations averages 37%. (On some reservations, the rate goes as high as 95%!) Indications are that Indian elders fare even worse than younger Indians do in the job market.

In addition, few of today's Indian elderly were employed in their youth, most having been involved in traditional subsistance economies and lacking education and access to the job market. Those who were employed usually worked at jobs which were not documented for Social Security purposes. Even rarer is the Indian elder today who is lucky enough to be receiving a pension!

According to the 1970 Census, over 50% of the nation's Indian elderly had incomes below the poverty level, yet they receive far less than they are proportionately entitled to from the various income entitlement programs. For example, the 1970 Census showed that only 45% of Indians over 60 received Social Security benefits - a lower rate than among the Anglo, Black, or Hispanic elderly. Another factor contributing to the low Indian participation in these programs could be the lower life expectancy of Indian people compared to their non-Indian cohorts. In 1980, the estimate increased to 65 years, but in comparison the non-Indian life expectancy in 1980 climbed to 73.3. This means that the average Indian person barely lives long enough to reach the age of eligibility for most entitlement programs. Those who do are not likely to collect benefits for as many years as their non-Indian counterparts.

The workshop participants identified several other factors that keep Indian elders from receiving the income supports they are entitled to under existing programs. For example, as a result of the complexity of rules and regulations governing federal entitlement programs such as Social Security or Veterans Administration programs, many Indian elderly never apply for benefits, or fail to complete the application process.

Some of the regulations create real hardships for Indian elders - for example, tribal dividends must be counted as income when SSI eligibility is determined. In addition, the Social Security program requires documentation of quarters worked, of marriage, and of age - all of which serve as barriers to utilization of programs, since this kind of documentation doesn't exist for many of today's Indian elders!

Another problem identified by the participants as affecting all programs is the lack of outreach and programmatic information being made available to the Indian community. This is compounded by the underrepresentation (usually absence) of Indians as staff members of these various agencies. Another administrative barrier is the length of the various forms that must be filled out just to apply.

In short, the participants felt strongly that the process of enrolling in entitlement programs is much too complicated and lengthy, and there is rarely sufficient assistance for the Indian elder to negotiate the "system".

In the area of employment, the fact that current laws prohibit earning excess money through gainful employment perpetuates the poverty cycle by discouraging elderly Indians from working. All too often, they feel, increases in the benefits from one federal program result in decreased benefits from another.

Finally, a characteristic of the Indian community in the past has been the willingness of the extended family to respond to the needs of their elderly relatives. However, this family support system is in serious jeopardy now as more and more younger members go to urban areas to find employment, leaving the elders at home to fend for themselves. The participants feel it is necessary that this not continue, and that appropriate action must be taken to reverse this migration of the youth.

It should be made clear that the participants were not asking for extravagant assistance, but only for adjustments in the existing system to make it possible for Indian elders to receive the benefits they are entitled to along with all other American senior citizens. They ask for additional assistance only if necessary to obtain adequate food, fuel, housing and medical care - the basics of life which many cannot afford today.

During the 1971 White House Conference on Aging, the Special Concerns Session on the Indian elderly identified a variety of concerns relating to income security with the goal that "the elderly Indian citizen should have an income which would permit him to live the rest of his life in health, decency, and dignity". This goal is as valid now as it was a decade ago.

PHYSICAL AND MENTAL HEALTH

Health Status. Health has surfaced on many occasions as an important issue affecting the lives of the nation's older Indians. An indication of the poor health encountered by Indians is their low life expectancy, which is approximately 10 years behind the rest of the population (65 years vs. 73 years in 1980). A number of diseases, such as tuberculosis and diabetes, are much more prevalent among Indian elders than among the non-Indian elderly. A recent national study conducted by NICOA found that the rate of tuberculosis is five times higher among the Indian elderly than among the non-Indian elderly. There is also an exceptionally high rate of adult-onset diabetes. On one reservation, 40% of all adults have diabetes.

Obesity, although not a disease, is a health problem that increases the severity of certain diseases and has been identified as a catalyst of other health problems, such as heart disease and diabetes.

Another health problem which affects the Indian elderly is alcoholism--although very few Indian elders are alcoholics. (In a study done by the Association of American Indian Physicians in 1978, only 4.8% of Indians treated for alcoholism were 60 years or over). But the problem of alcoholism among middle-aged and younger generations is contributing to the abuse of older Indians. While physical abuse is relatively uncommon, it is not unusual to hear of grandchildren or adult children asking for or taking what little resources are available to the elderly in order to purchase liquor. Many times this leaves the elder without the resources to purchase required staples. It should be noted that most Indian cultures stress sharing and giving as very desirable qualities, so the elders often feel compelled to share their resources if requested. On the one hand it is good to give, but on the other, it is not good to starve!

A variety of recent studies has shown that if minority elders live to age 60, chances are they will outlive their non-Indian counterparts--and will survive in better condition. This generalization seems to be true of the Indian elderly as well. For example, a study by the Association of American Indian Physicians in 1978 found that of the total number of outpatient visits made by Indians over age 45, 65% were made by those between 45 and 64. The rate decreases for those aged 64 to 74, then picks up again after age 75. This may imply that those who manage to survive past age 65 are actually healthier, as a group, than the "young old".

In the areas of mental health, elderly Indians, if they have any mental problem, are likely to suffer from some type of neurosis, such as anxiety or depression. As it is with the non-Indian elderly, the total number receiving mental health services in proportion to their population is low. However, in a study conducted by NICOA using the Duke University OARS instrument, the Indian elderly rated significantly worse in mental health than the non-Indian elderly. Further research is needed to determine whether this reflects the true picture, or is simply the result of using a questionnaire that is not sensitive enough to Indian culture.

Health Care. The Indian Health Service (IHS) provides comprehensive health services to Indians living on or adjacent to federal Indian reservations and Alaskan Native villages.

It's a common misconception that all Indians receive free health care from IHS. But nearly all urban Indians - about half the total Indian population - are not served by IHS. Consequently, very few elderly Indians in the city seek out health care, either because the cost of modern urban health care is too high or because the surroundings are too foreign. Preventive care and dental treatment are rarely sought. Most elderly urban Indians receive emergency health care or none at all. Yet when urban Indians do seek out health services, it is not uncommon for them to be refused service from public agencies because of the misconceptions that IHS and BIA will take care of them.

For the rural and reservation elders who are served by IHS, other problems arise in spite of IHS's significant efforts and contributions. Lack of transportation was mentioned frequently in the workshops as one of the most serious barriers to health care for reservation elders.

There are currently six nursing homes on Indian reservations. This means that only 3% of the 200 Indian reservations and rancherias in the U.S. have nursing homes on their land. Most of the six reservation nursing homes are understaffed, over-crowded, and financially insecure. If Shannas and Tobin's study of 1975 can be used as a guide, about 4,150 older Indians are in long term care institutions currently. Obviously, the great majority of these are in off-reservation nursing homes. The removal of these reservation elders far from their families, their native languages, foods, and customs is often a severe shock, leading to withdrawal and depression, even death. Obviously, the need for nursing homes is a problem that cannot be overlooked.

Workshop participants were also concerned with the need to prevent premature institutionalization by providing in-home and supportive services such as nutrition, transportation, homemaker, home health, employment programs, and so on. Participants felt that such programs are and will continue to be vital components in the total "continuum of care." However, the development of this concept cannot begin until the various governmental agencies such as the Administration on Aging, the Bureau of Indian Affairs, the Indian Health Service, the Administration for Native Americans, and the Health Care Financing Administration begin to coordinate their efforts.

SOCIAL WELL-BEING

Although a number of different Indian cultures exist in the U.S. today, traditionally all tribes respected and valued the elder for his wisdom and experience and honored the elder as the repository of tribal culture and history. The elder was the key to ensuring preservation of tribal culture for another generation. Moreover the family has always been valued highly in Indian cultures. The elders helped to teach and care for younger generations, and were in turn respected and cared for by the extended family.

Today, with the impact of modern society, these cultural norms are changing. The elders' traditional knowledge and wisdom is often less respected than before, as other kinds of knowledge appear more vital to many younger people. In addition, the extended family is often no longer intact as family members go to the cities for education or jobs, leaving the elders without the family support systems they could have relied on in the past. Elders in urban areas (approximately 48% of all Indian elders) tend to find themselves without traditional supports as the circle of available family members is reduced, and family members are away from the home for jobs or school or are debilitated by alcoholism.

Nevertheless, for most Indian elders the family is still the primary source of services and support. Studies show that although proportionately more Indian elders call upon the social services network at some time than the general population does, the elders' use of these formal systems is more sporadic and infrequent. Workshop participants agreed that development of services that enhance the existing tendency toward family care (e.g. in-home services, respite care, reimbursement of family members for care of the elderly) would be welcomed by the Indian community as a means of strengthening traditional values and seeing that elders are provided with the kind of care they prefer.

In addition to the natural support network provided in varying degrees by family and kin, most elders have available some aspects of a formal support network. If services exist on reservations, they may be provided by the tribe, county, state, or federal governments. The tribal government and its level of self-determination can have an important effect on the reservation elderly. On reservations where the tribal government has taken the needs of the elderly to heart, their lives have been greatly improved.

In urban areas, elders cannot take advantage of tribal services or, usually, of Indian Health Service programs. Although nearly every urban area has aging services, virtually no Indian elders participate in these programs. One reason is that urban services are almost never geared toward Indian elderly, who prefer to go to organizations established by and for Indian people. Other barriers to service include elders' lack of skill in speaking, reading or writing English; misinformed service providers who try to send the elderly back to the reservation for services they are entitled to in the city; transportation problems; lack of outreach to Indian elderly. "Invisibility" of Indian elders in the city is also a problem. The National Urban Indian Council estimates that although nearly half the elderly Indian population live in cities, they comprise no more than 1-5% of the total population in any major city, and only 0.4% of the entire U.S. population.

Participants agreed that housing and transportation are two of the most serious problems facing Indian elders, whether urban or rural. Overall, Indian housing is of poorer quality and is more crowded than dwellings of the general population. A national needs assessment of the Indian elderly completed by NICOA in 1980 showed that the housing stock of Indian elders is generally old and dilapidated, with 26% of the housing constructed prior to 1939. Twenty-five percent of the elders surveyed reported bedrooms occupied by 3 or more persons, and this indication of overcrowded conditions is supported by U.S. Census data showing three times as many Indian residences housing 7 or more persons as in the general population. In 1979-1980, the elderly reported service outages. of heat, water, and toilet systems at rates of 20%, 24%, and 15% respectively; 44% of all Alaskan respondents reported they suffered a heat outage during the preceding winter. The 1970 Census showed that 26.3% of Indian housing units had no plumbing, compared to 5.5% in the general population. Only 50% of rural Indian homes had complete bathrooms in 1970, and a third lacked piped water. Since the elderly tend to live in the most traditional homes, they likely account for a large percentage of this housing. In addition, the sanitation problems caused by lack of running water and plumbing facilities contribute to the high rates of diseases such as tuberculosis among the Indian population. Large numbers of Indian dwellings, especially on reservations, also lack electricity and telephone service.

Transportation is another severe problem for Indian elderly, urban and rural. It is one of the services most frequently requested by Indian elders and is probably the top priority for all Indian aging programs, since most Indian elders are not in a position to own or drive an automobile. Urban elders, especially those who are illiterate or not proficient in English, often find available public transportation frightening and difficult to comprehend. Urban service providers report that extremely few elders make use of existing public transportation, causing many urban elders to remain confined to their homes or immediate neighborhoods, isolated from the company and assistance of others outside their immediate family, and from needed medical and social services.

The transportation problem is compounded on reservations by severe climate, and by remoteness from health and social services, shopping facilities, medical care and even telephone service. Road conditions on most reservations are very poor. Many reservation roads are unpaved, and consequently impassable during winter weather or heavy rains. On all but the main highways on the Navajo Reservation, for example, the snow and mud limit transportation for 6 months out of the year. In today's society, with traditional means of subsistence dwindling and the migration of youth to urban areas, the elders left on remote areas of the reservation find it extremely difficult to obtain even the essentials of life such as food, clothing, wood and water.

Sky-rocketing energy costs have deepened both housing and transportation concerns within the past few years. Weatherization of homes, fuel assistance, and increased funding for reservation transportation services are sorely needed.

In addition, federal matching requirements for housing and transportation programs, and requirements that land be used as collateral for housing programs (land in federal trust status, such as reservation lands, cannot be used as collateral) effectively bar Indian tribes from participating in desperately-needed programs.

At least some services are available for elders on most reservations, often including Older Americans Act nutrition programs, Indian Health Service programs, and possibly HUD programs. Despite the existence of these services on most reservations, however, a national needs assessment conducted by NICOA indicates that the extent to which needs are met is inadequate. Workshop participants cited a number of factors for this inadequacy, including transportation problems, lack of service coordination, lack of outreach, and failure of state and federal programs to respond to Indian cultural norms.

Title VI of the Older Americans Act was passed in 1978 to respond to some of these concerns. This legislation gives tribes the option of receiving funding for aging programs directly from the federal government, bypassing the state. It was developed to enhance tribal sovereignty (the autonomy of tribal governments) and to give tribes an opportunity to develop aging programs that are better adapted to the culture and needs of their own reservation. The first Title VI programs were funded in October 1980.

Although the principle of direct funding has been welcomed by Indian people, Title VI currently contains a number restrictions that workshop participants found troubling. For example, only Federally-recognized tribes are eligible (excluding urban programs and state-recognized tribes), a tribe or consortium of tribes must have at least 75 elders in order to qualify for funding; only those 60 or older (or their spouses) are eligible for Title VI services; and Title VI grantees are required to ensure that certain services are being provided for their elders, thereby restricting tribes' ability to focus on the particular services most needed by the elders on their reservation.

OLDER AMERICANS AS A NATIONAL RESOURCE

The wealth of the Indian community lies within the value placed upon intangibles, such as culture, the preservation of family structures, and tribal beliefs.

To the vast population of America, numbering 262 million people with an elderly population of 23 million, the Indian community by comparison is microscopic, numbering just over one million with an elderly population of 83,000. As a national resource, this minute population would not affect a statistical variance. To the Indian community, however, without this valued resource, the culture will die, the language will cease to be spoken, and beliefs will no longer be practiced.

Consequently, one of the greatest concerns of the elderly is the preservation and revitalization of their cultures: "We have to have roots in order to grow." It is in this area that they feel their most important contributions can be made.

Many elders feel that Indian culture is being lost. Such characteristics as respect, discipline, religious practice, knowledge of the tribal language, and the use of tribal ceremonies are on the decline.

Basic to the preservation, the teaching, the authenticity of culture is the need to identify just where culture begins. It is not something one receives at birth, nor is it inherent in the blood; it has to be taught, and it has to be practiced. It cannot be found in modern day text books as some would suppose. But the Indian elder has this knowledge through years of practice and tribal tradition. Much discussion centered on ways to enhance the ability of Indian elders to pass on their heritage to younger generations. Recommendations emphasized the need to strengthen the traditional extended family in order to amplify the role of the grandparents in teaching their grandchildren the language, tribal customs, and religion. Participants stressed the mutual responsibility of elders and youth to ensure that the culture is carried on.

Participants also felt that if the elders are to fully exercise their role as a resource for their people, the area of education is critical. The elders stressed the need to modify hiring practices in educational programs such as Johnson O'Malley and Title IV-A of the Indian Education Act to encourage the use of tribal elders as bilingual-bicultural teachers. The elders also noted the problem of defining bilingual education so that it fits the needs of the community language group in relation to the majority culture.

In addition to education of the youth, education for the elderly must be available to assist them in leading a full and satisfying life, and to better equip them to contribute to their families and communities.

A special aspect of adult education is the need to give elders the tools to carry out political advocacy to achieve the reforms they believe are needed for their own well-being and the well-being of the Indian community.

In regard to education, whether for youth or elders, workshop participants noted a number of questions that must be answered during the planning process, for example: who sets priorities in education; what priorities should be set; what does the adult community want; and what roles should states and counties play in providing needed educational services?

In sum, the elders felt their greatest value as a resource for others was to actively ensure the preservation and revitalization of Indian culture.

But basic to preserving culture is the freedom to practice one's beliefs and traditions. The Indian community did not share in the basic constitutional rights to life, liberty, and the pursuit of happiness until passage of the Citizenship Act of 1924. However, the most basic right to many Indian people, the right to worship as one chooses, was not granted until 1978, when the Indian Religious Freedom Act became law. Many, Indian people still choose to worship as did their ancestors. To many culture is religion, religion is culture: there is no separation. "To deny, or in any way limit the practice of our culture, therefore, is to begin uprooting our very lives."

Consequently, workshop participants expressed deep concern that full religious freedom is still not accorded to Indian people. Examples:

a) Indian patients and inmates do not have free access to tribal medicine men for either counsel or treatment. Priests, ministers, and rabbis are granted free access to hospitals and penal institutions and are treated with the dignity accorded to their station in life. They are not searched; their religious sacraments are not inspected or desecrated. The same treatment and respect is not afforded to Indian religious leaders.

b) Indian inmates of most penal institutions are not permitted to practice traditional religious rites.

c) Officials at international borders still restrict passage for attendance at religious ceremonies, and refuse to allow religious sacraments to be transported for the purpose of worship.

d) Sacred sites continue to be destroyed (for example, flooding of Cherokee burial grounds by the Tellico Dam), and free access is not permitted to other places deemed holy by tribal elders.

e) Many Indian religious artifacts are on display in museums, others are stored in warehouses and will never again be properly used in religious ceremonies.

CREATING AN AGE-INTEGRATED SOCIETY

The Indian people have traditionally maintained a very close-knit society. Children, young men and women, and the elderly lived together in extended families caring for each other and enjoying the mutual company. This societal bond has been weakened by the acculturation of Indian people and by factors such as increased mobility, education, inter-tribal and inter-racial marriages, termination of Indian reservations, and the Bureau of Indian Affairs relocation program.

One of the most frequently expressed of all concerns at the conference was the weakening of the extended family, and the declining role of the elders as teachers and advisors to younger generations.

An important aspect of this problem is the large outflux of younger Indian people from the reservations to seek education or employment. Currently, half the Indian population live in cities. This "urban migration" weakens intergenerational bonds, removes young children from ongoing socialization in Indian culture, and often leaves the elders without the care and companionship formerly provided by the extended family. Because of these problems, the elders view economic development on the reservations as critical to maintaining the social fabric of Indian lif "We must provide jobs so our young people can stay on the reservation."

Other measures are needed to increase the elder's involvement in and contributions to the community. One example of such measures: expansion of employment opportunities for those over 60, including CETA slots for elders. Participants also recommended that tribes increase the involvement of elders in tribal government. Formerly, it was the elders who guided the affairs of the tribe, and a few tribes are returning to that concept with the development of advisory councils of elders to assist the tribal council in governing.

Workshop participants also stressed the need to offer assistance to families who want to care for their elders in the home. In many cases, both the elders and their families would prefer that elders be cared for within the family setting in accord with traditional values, but the families simply lack the resources to offer this care. Workshop discussions emphasized the need for assistance and incentives such as training of adult children to care properly for an ailing parent; availability of respite care and other in-home supportive services; and reimbursement of a family member for care of the elder.

Other workshop discussions focused on the problems facing Indian youth, and the relationship between the young and old. Many young people, both on and off the reservation, are growing up today with little knowledge of their tribal culture or history. Fluency in speaking the tribal languages has decreased tremendously over the last two generations.

The elders expressed a strong desire to become more involved in public education as a means of counteracting these trends. The workshop participants felt that the elderly can and should become a vital part of the educational system by providing instruction in the schools. Classes in the native language, tribal history and traditional activities could be taught by the elderly. Workshop participants recommended that hiring practices in education programs be revised to encourage employment of tribal elders as bilingual-bicultural teachers. The Foster Grandparents Program, funded by ACTION, has provided some opportunity for the elderly to work with the youth in the school setting. In four tribes which currently operate a Foster Grandparents Program, the program has helped the youth establish a better understanding of their cultural heritage.

The Indian Child Welfare Act (P.L. 95-608), passed in 1978, was designed to stem the growing percentage of Indian children who were being placed in non Indian homes for foster or adoptive care. The philosophy behind this legislation is that the extended family and the tribal family is the best environment for Indian children. The law grants jurisdiction over Indian children on reservations to the tribal courts, and requires that every effort be made to place Indian children in Indian homes, preferably with a member of their extended family. This means that Indian grandparents, who have traditionally played an important role in training and caring for children, have an unusually high number of foster children in their care. A nationwide survey indicated that 20-25% of all households headed by Indians aged 45 or older have one or more foster children. An additional percentage care for children during the day.

Programs for the elderly which are age-segregated exclude these children, and in essence bar the elder also from participating. An example which has been cited many times by the elderly is the Title III-C nutrition program, which requires that any person under age 60 must pay the full cost of the meal. Many elders who would like to participate in Title III-C programs simply cannot afford to pay the cost of meals for their grandchildren, and so do not participate. From the Indian perspective, such regulations not only keep elders from needed services but also prohibit a good opportunity for intergenerational learning and enjoyment.

RESEARCH

The number of Indian elderly is sure to grow rapidly over the next decades, since the total Indian population is expanding (its birth rate is currently higher than that of any other population group in the U.S.), and at the same time the life expectancy of Indian people is rising steadily, to 65 years in 1980.

The workshop participants agreed that research is needed to identify the characteristics of this growing population. Such research could provide the basis for effective policy development and for planning more appropriate services for Indian elders.

It has become clear that research on the non-Indian elderly will not suffice for these purposes. For example, cultural differences strongly affect the kinds of support networks available to the elderly, the elders' preferences for health and social services, the role of elderly in family and community, and so forth. Nutritional patterns, disease rates, life expectancy, and other biomedical phenomena also differ sharply between the Indian and non-Indian populations. Workshop participants concluded that research on these biological and cultural differences could provide the foundation for much-needed changes in policies and services to better respond to the needs of the Indian elderly.

The workshop discussions emphasized the lack of data currently available on the Indian elderly. Good research and reliable statistics on the Indian elderly are very hard to find. In fact, pertinent research in either the social or biological sciences is sparse even when compared with the amount of data available on elderly of other minority groups.

In addition, workshop participants expressed concern about the quality of the research that has been done. One of the over-riding concerns was the lack of sensitivity or relevance to Indian life. Areas of inquiry must be evaluated and expanded to ensure that the needs, strengths, and characteristics of the Indian elderly will be accurately reflected in the resulting data.

One of the most serious concerns of workshop participants was the overwhelming tendency of researchers to try to fit Indian elderly into the "non-Indian mold", rather than studying them within the context of their tribal culture, history, values, and political realities. As many workshop participants observed, one result of this tendency has been a faulty and overly negative picture of Indian elders simply as troubled versions of Anglo senior citizens. Policies and services designed on the basis of this picture will not be adequate.

In addition, previous analyses of the Indian elderly have often failed to recognize the tremendous diversity within the Indian population. More than 400 Indian groups, speaking over 250 distinct languages, live in the U.S. today, and many of these groups differ strikingly in culture. Roughly half of the U.S. Indian population resides in urban areas, with the remainder living on Federally- or state-recognized reservations, or in non-reservation rural areas. Yet results of studies that were limited to single communities, reservations, or regions are often extrapolated to the total Indian population as though this diversity did not exist.* Research to date has failed even to clearly address the nature and implications of this diversity.

Another aspect of the same issue is inter-generational diversity within the Indian population, a phenomenon of even greater dimensions among the Indian than the non-Indian population. Many of today's elders were raised in traditional tribal lifestyles; in the Western U.S., for example, many elders speak little or no English. In contrast, the majority of today's middle-aged generation has had much more exposure to the non-Indian world, including education (frequently in off-reservation boarding schools). What will be the characteristics, needs, and choices of these people - tomorrow's elderly? What long-range plans should be made to accomodate this coming generation of elders? Almost no research has addressed this topic.

Related to this issue is the lack of research on significant life experiences of the Indian elderly and middle-aged. During these people's lives, major upheavals have been caused by federal policies such as the Indian Reorganization Act of 1934, the BIA relocation program, and termination of federal trust status for a number of reservations. These events have undoubtedly left scars on the elderly of today and tomorrow. The nature and extent of those scars remain to be investigated.

Workshop participants were also concerned that most research on Indian elderly does not benefit the Indian community. The participants identified two reasons for this: (1) most research has little relationship to the actual situation in the community, and (2) very few researchers disseminate their findings to the Indian community, and those who do rarely put their findings in a form that is understandable to the non-scientist.

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* It might be noted that extrapolations of such data are made even more uncertain by the lack of accurate population statistics for Indians.

Finally, it was often noted that an increase in the number of Indian people trained to carry out research in the social or biological sciences is badly needed, and would likely help to alleviate many of the problems identified in the research workshops.

RECOMMENDATIONS

One theme emerges above all others:

We are Indian people. Let us be who we are.

The desire to maintain and preserve the tribal cultures, to be true to their Indianness, was more important to the elders than any other goal.

With this premise as the foundation, the following emerged as the major recommendations from the conference.

1. FAMILY-BASED AND AGE-INTEGRATED PROGRAMS

Basic to the desire for cultural preservation, according to the elders, is the need to strengthen and enhance the Indian family. The extended family is the traditional foundation of Indian society. Even more important, unless the youth and the elderly are brought together, traditional Indian culture will cease to be passed on.

The elders suggest that this policy recommendation be implemented in the following ways:

- Increase incentives and supportive services for home care of the elderly. These might include increased homemaker, home health, and respite services, training of adult children to care for elderly parents, and reimbursement of family members for care of the elderly.

- Change funding structures to encourage age-integrated rather than age-segregated services. An example is elderly nutrition programs which exclude grandchildren of participants. Many Indian elders who care for children do not participate in Title III programs because they cannot afford to pay for the grandchildren's meals. Not only does this regulation keep elders from participating, it also removes a valuable opportunity for intergenerational activities.

- Expand the role of the Indian elderly in educating youth by employing elders in the schools as teachers or teachers' aides in the areas of tribal language, culture and history, and by expanding programs such as the Foster Grandparents Program.

2. DIRECT FUNDING FOR SOCIAL SERVICES TO INDIAN TRIBES

Indian tribes have long advocated that social service funds be channeled directly from the Federal government to the tribes, bypassing the state. Title VI of the Older Americans Act sets a precedent for such direct funding in aging.

There are several reasons for this recommendation. Direct funding acknowledges the legal government-to-government relationship between the federal government and the tribes. Moreover, states frequently have difficulty providing social services to Indian reservations because of their remoteness, cultural and language differences, and so forth. Direct funding may actually prove less costly and more effective by allowing tribes to develop services better suited to the real needs of the reservation elderly.

Relating this recommendation to the previous one, we are aware that many non-Indian advocates prefer age-segregated services for the elderly. Direct-funded programs to tribes should be flexible enough to allow for intergenerational services, but funding for non-reservation programs could continue to be age-specific if that should be deemed more appropriate for the general population.

3. GUARANTEED ANNUAL INCOME

The elders believe that in order for any human being to make his full contribution to society, he must have an income adequate to obtain at least the bare essentials of life - food, clothing, shelter, fuel, medical care.

Supplemental Security Income (SSI), as currently structured, is not sufficient to provide these essentials.

4. LONG TERM CARE FOR INDIAN ELDERS

There is a growing awareness of the tremendous need for long term care for Indian elders. Funds and technical assistance need to be made available for the development of culturally-appropriate long term care facilities on reservation lands, as a necessary part of a continuum of care which includes a range of family and community-based services.

5. AVAILABILITY AND APPROPRIATENESS OF SOCIAL SERVICES FOR INDIAN ELDERS

Under the existing social service delivery system, Indian elders are severely underserved. The services they do receive are frequently not appropriate to Indian culture and preferences. These generalizations are true for reservation Indians, and perhaps even more so for the elder residing in urban areas.

Additional funding and new programmatic initiatives are needed to make these services more accessible and culturally-appropriate to Indian elders. Major programmatic recommendations:

- Staffing of area agencies on aging and other service provider agencies should include Indian people and persons sensitive to Indian culture.
- Strengthen outreach to Indian people. Outreach workers must be sensitive to Indian culture, and should be bilingual if necessary.
- Increase funds for transportation, nutrition and housing programs for Indian elders.
- Develop aging services such as nutrition/socialization programs specifically for Indians in urban areas. Preferably these should be developed by or in conjunction with Indian organizations, and should allow age-integrated programs if desired by the elders.

In summary, these recommendations represent the major themes expressed by conference participants. Underlying each of the recommendations is the desire to provide Indian elders with dignity in their last years. Most basic of all to their dignity and well-being is the freedom to be who they are: the freedom to be Indian.

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Report of
the Mini-Conference on
Hispanic Aging

MCR-25

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Hispanic Aging

Introduction

There is a harsh irony surrounding most Hispanics living in the United States today. We are told that the 1980's is the "Decade of the Hispanic." Hispanics soon may be the largest minority group in the U.S. More than this, in a few short years Hispanics will lose their "minority" status altogether in cities such as Los Angeles. Hispanics will soon outnumber Anglos there. And, population statistics aside, elements of Hispanic culture have deeply penetrated American popular tastes and styles.

While not denying that progress in behalf of our social betterment has been made in recent years, nor losing a sense of optimism about the future, we Hispanics nonetheless confront each day the knowledge that many of us remain among the nation's most isolated and poor citizens. What is true of Hispanics in general is profoundly true of the Hispanic elderly in particular.

Closely tied to proud and diverse cultures--Mexican American, Cuban, Puerto Rican, Central and South American--yet unified by a common language, most older Hispanics feel themselves cut off from the cultural norms and language of those who make most of the decisions affecting their welfare. Most explicitly, their sense of isolation expresses itself in well-documented underuse of social services that, on the surface, appear readily available to them. The 1980 national needs assessment of Hispanic elderly, conducted by the Asociacion Nacional Pro Personas Mayores, showed that 76 percent reported a need for social services. Despite this high need, 40 percent of older Hispanics use no social services. Twenty-five percent use only one service. The fundamental cause of this less-than-full use is not elusive. It appears again and again in the testimonies and recommendations in the next pages and can be simply stated: social services and programs based on cultural values different from those of the potential users, no matter how expertly-designed and well-intentioned, and delivered by persons who seldom speak their language, are doomed to underutilization.

Because of older Hispanics' low participation in social policies and programs, the importance of the 1981 White House Mini-Conference on Hispanic Aging cannot be overstated. The mini-conference was the first formal opportunity for older Hispanics to help shape national policies on aging. Mini-conference recommendations, and participation by senior Hispanic delegates, will insure that the voice of older Hispanics is plainly heard at the White House Conference on Aging in November, 1981.

The Hispanic mini-conference took place from January 5 - 8, 1981, in Los Angeles, California. The Asociacion Nacional Pro Personas Mayores (National Association for Hispanic Elderly) was the official convener of this event. About 400 Hispanic seniors, service providers, and professionals in the field of aging participated in the mini-conference. To prepare for the conference, the Asociacion Nacional sponsored six regional Forums on Hispanic Aging around the country in the fall of 1980. The one-day forums were held in New York, Washington, D.C., Miami, Chicago, Houston, and Los Angeles. More than 1,200 Spanish-speaking elderly attended the forums to present and hear testimony about their needs and concerns. A summary of forum testimonies contributed significantly to discussions at mini-conference workshops. The forums helped assure that the White House Conference on Aging would hear the voice of all Hispanic elderly from different parts of the country: Cubans, Mexican Americans, Puerto Ricans, and Central and South Americans.

One hundred and ten older Hispanics testified at the forums. They and the mini-conference recommenders spoke not merely for themselves but also for thousands of Hispanic elderly. Their testimony and recommendations, often spoken in syllables of pain, focused on language barriers, discrimination, poverty, poor housing, crime, inadequate health care and nutrition, lack of transportation, the need for employment, and the need for culturally sensitive legislation, programs, and personnel to serve older Hispanics. Yet through this litany that described their status as second class citizens, they spoke with a hope that belied their condition. Their testimony and recommendations spoke of a hope in the basic fairness of America.

The following summary of recommendations and testimonies can serve as a blueprint to change current policies and programs and to create new ones that respond to older Hispanics' needs and concerns. Specific recommendations are listed after the summary. They make it clear that no single issue exists in isolation. All issues are, therefore, linked to each other.

This report is limited to 20 pages; the Asociacion Nacional cannot list every mini-conference recommendation here. We have consolidated these recommendations, striving always to be as comprehensive as possible and to reflect the representation of all Hispanic subgroups at the mini-conference. Consolidation has also occurred because this final report is written in Spanish and

English. We want to maximize the report's usefulness to the Hispanic elderly. Recommendations and testimonies were spoken originally in both languages; so we have remained faithful to the bilingual presentation here.

Summary of Recommendations/Testimonies

Income Maintenance: Only 55 percent of older Hispanics in the U.S. receive Social Security benefits, although Social Security is the main source of income for Hispanic elderly. Most older Hispanics are poor; average yearly family income is only $3,936. Older Hispanics name income as their most urgent problem. Those who do receive Social Security attest to the gross inadequacy of payments. This issue is linked closely with inability to gain subsidized housing, inflation, poor employment opportunities, Social Security regulations governing employment income ceilings, cost of health care, utilities, etc. The Hispanic elderly further attest to difficulty with income forms in English and to fears of an increase in the Social Security eligibility age.

Health Care: Many older Hispanics suffer from diseases and consequent functional disability. Due to poverty and a long, arduous work life, Hispanics tend to age earlier than Anglos. Yet many do not have adequate health care. They testify that the Medicare/Medicaid program is inadequate. Costs of medicine are prohibitive. Preventive physical and mental health care are nonexistent. Fear or mistrust of hospitals deters them from seeking needed care. Adequate long-term care as an alternative to institutionalization is required. Lack of nutrition centers is a health problem. Transportation to clinics or the doctor is often not available. Lack of bilingual/bicultural health personnel further impedes older Hispanics' access to health care.

Housing: Only 9.7 percent of Hispanic elderly live in extended families. Few can rely on family for economic assistance because of the family's generally poor economic state. Yet their own overwhelming poverty makes housing costs prohibitive to older Hispanics. Few of them receive housing subsidies. Those who do suffer interminable waiting lists for subsidized housing and discrimination in applying for that housing. Many older Hispanics live in substandard housing; but many would rather remain in their home, even when the dwelling needs repair, than to move to a new, unfamiliar location. They need refurbishing services and income supports to maintain their home.

Transportation: Most of the Hispanic elderly rely on public transportation, or family and friends, for transportation. Inadequate transportation is a key problem linked to health care, employment, crime, nutrition, and other issues. Two main aspects of the transportation difficulty are: (1) the infrequency of transportation (especially in rural areas) and (2) modes of transportation that fail to provide for special characteristics of the elderly (e.g. poor health causing difficulty in climbing steep bus stairs). The lack of emergency transportation for health needs often isolates the older Hispanic, compounding his/her health problem.

Language: In a recent study, 86 percent of the Hispanic elderly respondents chose to be interviewed in Spanish rather than in English. Spanish is clearly the preferred language of this group, and it is often the only language in which they communicate. Lack of bilingual service personnel, forms, and consumer information greatly impedes older Hispanics' use of social services. The need for bilingual/bicultural services and service providers relates to all other needs and recommendations described in this report.

Crime: Muggings, shootings, threats, and vandalism keep many older Hispanics locked in their homes, living in fear. Fear of crime, together with the language barrier, insufficient income, and lack of transportation, guarantee a sentence of solitary confinement for many of the Hispanic elderly. Older Hispanics ask for crime prevention programs that consider their needs, income, and ability to deter crime.

Legal Aid: There is a serious lack of bilingual, low-cost legal aid services for the Hispanic elderly. This kind of assistance is needed especially in consumer affairs such as disputes over rent. The dearth of bilingual legal assistance reinforces the Hispanic elderly's sense of being second-class citizens.

Nutrition: Nutrition sites are often far from Hispanic neighborhoods. Many do not serve ethnic meals that would appeal to older Hispanic consumers. Nutrition service providers and Hispanic elderly consumers need information on how to prepare balanced ethnic meals. Food stamps are another major nutritional concern. Many older Hispanics rate the food stamp program inadequate, even though many must utilize the program. The food stamp program requires improvement to permit greater access by needy older Hispanics. Policymakers should consider alternative food subsidy plans that may serve older Hispanics and other persons better than the current program.

Employment: Lack of Social Security and other pensions force many older Hispanics to continue working long after they are able to do so. Many work in blue-collar positions that do not allow them to accumulate sufficient Social Security benefits despite many years of work. This cruel cycle is compounded by the fact that there are few employment opportunities for the elderly -- even fewer for monolingual older persons. Employment income ceilings imposed by Social Security prove a serious hardship when Social Security payments are low (as they are for most older Hispanics). Job projects like the Department of Labor's Senior Community Service Employment Program should be expanded. Bilingual assistance in fighting employment discrimination is also needed.

Rural Concerns: While most older Cubans and Puerto Ricans live in cities, a significant percentage of Mexican Americans and other Hispanic elderly live in rural areas. They have special needs in income maintenance, employment, transportation, and health care. These needs relate to rural Hispanics' relative isolation and early aging due to difficult manual labor. Older farmworkers likewise require health programs and other services that consider their unique working conditions and migratory patterns.

Aging Network: The Hispanic elderly attest to the need for Older Americans Act legislation targeting older Hispanics for services; for recruitment of bilingual/bicultural personnel in State Units on Aging and Area Agencies on Aging; for training of older Hispanics as paraprofessionals in Aging Network; for participation of the Hispanic elderly in making decisions on aging policy; and for more research on their needs, demographic characteristics, and reasons for underuse of social services..

Recommendations

The following is a summary of the many recommendations made at the Regional Forums and at the National Mini-Conference on Hispanic Aging. They are divided into six topic areas. This summary can be used as a basis for developing policies and programs that will enhance the life of all older persons.

I. Economics

A. Income

1) The Social Security eligibility age of 65 should not be raised, since raising it would exclude many older Hispanics who age earlier than the dominant population.

2) The earned income ceiling allowed to Social Security recipients should be raised to $7,000 so that older Hispanics can supplement their low incomes without penalty to their Social Security benefits.

3) The federal government should conduct research on why relatively few eligible older Hispanics receive Social Security benefits and on how more of these persons can learn about and obtain Social Security.

4) States should amend their legislation to prevent the lowering of Old Age Assistance benefits as Social Security benefits are increased.

5) Social Security and SSI eligibility forms and other pertinent documents should be printed in Spanish.

6) Income service offices should hire more bilingual/bicultural staff in areas with large Hispanic populations.

7) Employers who contract migrant elderly workers for any amount of work done should be required to make Social Security payments, and the farmer should be defined as the employer, not the contractor or crew leader.

8) The Social Security Administration should compile a census on the Hispanic population receiving Social Security benefits, and a projection should be made of those who will be receiving assistance in the next 10 years.

B. Employment

1) Congress should continue to fund the Title V Senior Community Service Employment Program, and should mandate special provisions that provide an incentive for program operators to hire minority older persons.

2) CETA regulations should provide for outreach campaigns to unemployed Hispanic older workers so that they may become gainfully employed in CETA programs.

3) The federal government, through OSHA, should require that all signs indicating industrial hazards (such as "Danger," "Flammable," "Do Not Enter," etc.) be printed in both Spanish and English.

4) The federal government should mandate that all industrial first aid kits, as well as safety equipment, such as fire extinguishers, contain instructions on their use in both Spanish and English.

5) The federal government should provide incentives for CETA operators, both public and private, to hire Hispanic older persons and train them to conduct bilingual worker safety training programs.

Careful attention should be paid to avoid conditions of exploitation and indignity when salary and volunteer stipend rates are established for Hispanic older persons.

II. Physical and Mental Health

A. Medicare

1) Medicare coverage should be broadened to cover preventive and health maintenance services for older Hispanics. This should include increased coverage for home health care.

2) Medicare coverage should be expanded to include costs for out-of-hospital prescribed drugs; eye examinations and eyeglasses; hearing aids; dental exams and dentures; convalescent care after acute illness; routine physical exams; and in-home mental health care.

B. Long-Term Care

1) Older Hispanics should be appointed to advisory and decision-making bodies concerned with planning and operation of comprehensive health service systems at the national, state, and local level.

2) Research and programs should be carried out concerning informal support systems of older Hispanics. Programs to enhance these non-institutional mental and physical supports should be initiated.

3) Eligibility for long-term care should not be based on chronological age, but on functional disability of the older person.

4) More bilingual/bicultural health professionals should be recruited to provide care to the Hispanic elderly. Medical training programs should include curricula on the unique physical and mental health needs of older Hispanics. The Hispanic elderly themselves should be trained as paraprofessionals to provide health care to their peers.

C. Nutrition

1) Nutrition education programs for older Hispanics and nutrition service providers should be instituted. These programs should focus on how to plan balanced meals that reflect the ethnic food preferences of each Hispanic subgroup: Cubans, Mexican Americans, Puerto Ricans, and Central and South Americans.

2) The food stamp program should be improved to allow greater access by needy older Hispanics and to upgrade client satisfaction with the program.

III. Social Well-being

A. Housing

1) Public housing policy should mandate that every conceivable effort be made to preserve the ability of the Hispanic older person to remain in his or her own home and neighborhood. One method by which this could be achieved is to adjust the guidelines for the rent supplemental programs. This adjustment would allow Hispanic Elderly to qualify for supplemental rent support to help cover the cost of keeping their own homes.

2) Congress should enact special housing legislation to fund and encourage private housing renovation programs in Hispanic neighborhoods.

3) The federal government should continue to assist state and local governments in implementing home repair and weatherization programs for Hispanic elderly. While expanding the appropriations, the regulations should also be minimized to streamline the process of completing these tasks. In addition, the federal government should provide incentives to focus CETA and community service projects on these programs.

4) The Department of Housing and Urban Development and DHHS should work together in resolving the financial and bureaucratic difficulties which impede the development of culturally sensitive housing projects for the Hispanic Elderly.

5) The government should provide incentives for construction of or expand more low-cost housing units to shorten the long wait for subsidized housing that many older Hispanics must endure.

B. Transportation

1) Model programs for 24-hour emergency transportation systems with bilingual transportation providers should be established in rural and urban areas to serve older Hispanics.

2) Because of the special role public transportation plays in the lives of the elderly, it is important that all public transit districts should have an advisory committee of senior citizens. The composition of this advisory committee should reflect the ethnic diversity of the nation, as well as of the state and community it serves.

3) The federal government should provide special incentives and flexible regulations for rural transit districts in order to establish programs for the Hispanic elderly.

C) Law and Justice

1) An anti-crime task force composed of Hispanic and Spanish-speaking officers should be established. Their mission would be to assist and train the Hispanic Elderly in crime prevention.

2) The federal government should provide funding and encouragement to state and local governments in order to establish bilingual crime victim assistance programs.

3) The federal government should provide funds and encouragement to state governments, local and national bar associations, and to local legal aid groups, to develop and implement legal assistance telephone "hot lines" in Spanish and English. This "hot line" service should be supplemented by bilingual tapes,

played over the phone, focusing on crime prevention, consumer issues, landlord/tenant rights, crime assistance to victims, legal procedures, small claims court rights, and related issues.

D. Education

1) Gerontology centers should establish curricula focusing on the culture and special needs of the Hispanic elderly.

2) Educational programs in Spanish, focusing on aging problems, preretirement, and available social services, should be developed and broadcast through media outlets.

E. Language

1) The use of bilingual/bicultural personnel in service provision should be mandated when service delivery is targeted to monolingual older persons.

2) Spanish media should be used to provide outreach, information and referral, social service information to Hispanic older persons.

IV. Research

1) The Aging Network and universities should seek to identify, train, and promote Hispanic researchers working in the field of Hispanic gerontology.

2) Research should be conducted on chronological age vs. functional age among Hispanic elderly, thus providing a much-needed data base for the development of functional age-sensitive programs.

3) In-depth analyses of barriers to service utilization by Hispanic elderly should be carried out.

4) In-depth demographic analyses of the 1980 Census should be made. These analyses should be used to modify or expand services to older Hispanics, given the rapid growth of and dramatic shifts in Hispanic population patterns.

5) All governmental entities related to aging should focus on, and set aside research monies for, further development of minority research on aging.

V. Aging Network/Legislation

1) The Administration on Aging, in cooperation with minority aging organizations, should develop a national policy for serving the minority elderly. The AoA would be responsible for assuring the compliance of State and Area Agencies with this national policy.

2) Agencies that assume responsibility for serving the Hispanic Elderly Community must employ bilingual/bicultural personnel. State governments, through a single state agency on aging, should be responsible for assuring that bilingual and bicultural personnel are employed in those AAA's whose PSA's encompass Hispanic communities.

3) Title III regulations should mandate that SUA's and AAA's contract an equitable percentage of their service dollars to minority organizations.

4) Strengthen the Title IV Cranston Amendment of the OAA (1978) for the training of minority persons in the field of gerontology.

5) Reinstate the minority language of the 1973 OAA amendments, targeting minority older persons as prime recipients of OAA programs.

6) Create an amendment to the OAA, which requires SUA's and AAA's to provide service to limited English-speaking older persons in their native language (H.R. 6150).

VI. Cultural and Spiritual Well-being

1) Since loneliness, isolation, and morale are reported to be of serious concern to older Hispanics, providers of services must be sensitive to the life-satisfaction needs of these older persons by enhancing informal support systems.

2) All policies and programs targeting older Hispanics should account for the unique cultural characteristics and needs of each Hispanic subgroup: Cubans, Mexican Americans, Puerto Ricans, and Other Hispanics.

3) Churches and other religious institutions should establish outreach and support programs for older minority persons. Since the church's role in the lives of older Hispanics is recounted time and again, the Church has a moral responsibility to enhance this group's spiritual well-being.

Conclusion

The Asociacion Nacional Pro Personas Mayores hopes that this report will serve as a discussion paper to promote new policies and programs that serve older Hispanics effectively. In these few pages it has been impossible to create in-depth policy perspectives on all the needs of the growing, changing U.S. Hispanic community. Nevertheless, we believe this document can be an effective basis on which to create such perspectives. The Asociacion considers it an honor to have sponsored the regional Hispanic forums and to have been the official convener of the White House Mini-Conference on Hispanic Aging.

Reporte final de la Mini-Conferencia sobre la vejez hispana -- presentada por la Asociación Nacional Pro Personas Mayores

Introducción

La mayoría de los hispanos de los Estados Unidos vivimos una ironía. Por una parte, se nos dice que los años de los 80 son "La década de los hispanos." El grupo hispano pronto puede llegar a ser la minoría más grande de los EE.UU. Es más, dentro de pocos años los hispanos seremos la mayoría en ciudades como Los Angeles. Aparte de las estadísticas de población, elementos de la cultura hispana han penetrado profundamente los gustos y estilos populares de este país.

Por otra parte, aun sin negar que se han efectuado progresos en los ultimos años en pro de nuestro mejoramiento social, y sin perder el optimismo por el futuro, nos enfrentamos diario con que muchos de nosotros aun permanecemos entre los ciudadanos más aislados y pobres. Esta realidad de los hispanos en general se profundiza todavía más en el caso de los hispanos ancianos.

Aferrados a diversas y orgullosas culturas--mexico-americanas, cubanas, puertorriqueñas, centro- y sudamericanas--pero unificados por un solo idioma, la mayoría de los ancianos hispanos se sienten distanciados de las normas culturales y el idioma de aquellos que hacen la mayoría de las decisiones que afectan su bienestar.

Más explicitamente, su sentido de aislamiento se expresa en la bien documentada falta de uso de los servicios sociales que en la superficie aparecen inmediatamente accesibles a ellos. El estudio de las necesidades de los ancianos hispanos, realizado por la Asociación Nacional Pro Personas Mayores, demuestra que un 40% de los ancianos hispanos no utiliza los servicios sociales, y un 25% utiliza solamente un servicio, no obstante que un 76% reporta necesidad de servicios sociales. La causa fundamental de esta poca utilización no es difícil de encontrar. Se demuestra una y otra vez en los testimonios y recomendaciones de las páginas siguientes y puede expresarse sencillamente: serán poco usados los programas y servicios sociales que se basan en valores culturales que no sean los de la gente destinada a usarlos, por mejor diseñados e intencionados que sean, sobre todo si el personal profesional no habla, o habla poco, el idioma de esa gente.

Por todo esto, la Mini-Conferencia de la Casa Blanca sobre la vejez hispana fue de suma importancia. Ofreció la primera oportunidad formal para que los hispanos ayudaramos a formar las polizas sobre la vejez. Las recomendaciones de la mini conferencia y la participación de los delegados ancianos hispanos asegurarán que la voz de los ancianos hispanos sea escuchada en la conferencia de la Casa Blanca sobre la vejez en noviembre de 1981.

La mini conferencia hispana tuvo lugar del 5 al 8 de enero de 1981 en Los Angeles, California, convocada por la Asociación Nacional Pro Personas Mayores. Unos 400 ancianos hispanos, proveedores de servicios, y profesionales en el campo de la vejez participaron en ella. Como preparación para la conferencia, la Asociación Nacional patrocinó foros regionales sobre la vejez hispana en Nueva York, Washington, D.C., Miami, Chicago, Houston, y Los Angeles. Más de 1,200 ancianos de habla hispana asistieron para escuchar testimonios acerca de sus necesidades y preocupaciones, presentados por 110 ancianos. Sumarios de estos testimonios se usaron en los talleres de trabajo durante la mini conferencia. Los foros ayudaron a asegurar que la Conferencia de la Casa Blanca sobre la Vejez escuche la voz de todos los hispanos ancianos del pais, mexico-americanos, cubanos, puertorriquenos, centro- y sudamericanos. Los dolorosos testimonios y recomendaciones de los foros y de la mini conferencia se enfocaron en la barrera del idioma, discriminación, pobreza, mala vivienda, crimen, servicios inadecuados de salud y de nutrición, falta de transporte, la necesidad de empleo, la necesidad de una legislatura culturalmente sensible, y programas y personal para servir a los ancianos hispanos.

A pesar de esta letanía que describe su condición de ciudadanos de segunda clase, hablaron con una esperanza que desmiente esta condición. Su testimonio y sus recomendaciones mostraron una esperanza en la justicia básica de América.

El siguiente sumario de recomendaciones y testimonios puede servir de esquema para cambiar las pólizas y programas actuales y crear nuevos que respondan a las necesidades de los ancianos hispanos y sus preocupaciones. Después del sumario, se dan recomendaciones específicas. Es obvio que no existe ningún tema aislado; se encadenan unos a otros.

Este reporte se limite a 20 páginas; por esto la Asociación no puede imprimir en él cada una de las recomendaciones. Las hemos consolidado, tratando de ser lo más comprensivos posible, y de captar la voz de los subgrupos hispanos que participaron. Esta consolidación también se debe a la índole bilingüe del reporte.

Sumario de recomendaciones y testimonios

Mantenimiento de ingresos: Solamente un 55% de los ancianos hispanos en los Estados Unidos recibe beneficios del Seguro Social, a pesar de que éste es una de las fuentes principales de ingreso monetario de los ancianos hispanos. La mayoría de los ancianos hispanos son pobres; el ingreso anual promedio de la familia es $3,936. Los ancianos hispanos nombran el ingreso monetario como su problema más urgente. Los que sí reciben Seguro Social atestan a lo inadecuado de los pagos. Este problema está fuertemente encadenado a la inabilidad de obtener vivienda subsidiada, la inflación, malas oportunidades de empleo, reglas del Seguro Social que gobiernan el límite de los ingresos, el costo de servicios de salud, de utilidades, etc. Además, los ancianos hispanos confirman la dificultad que tienen con formularios escritos en inglés y su temor de que haya un incremento en la edad para recibir beneficios del Seguro Social.

Servicios médicos: Muchos ancianos hispanos sufren de enfermedades y consecuentamente de disabilidad funcional. Debido a la pobreza y a su prolongado y arduo trabajo, los hispanos tienden a envejecer antes que los anglosajones. Sin embargo muchos no reciben servicios médicos adecuados. Ellos testifican que los programas de Medicare/Medicaid son inadecuados, cuestan más de lo que pueden pagar, que no existen servicios preventivos de salud mental y física, que el miedo y la falta de confianza los impiden buscar el cuidado necesario. Se requieren servicios adecuados a largo plazo como alternativa a la institucionalización. Falta de centros de nutrición constituye un problema para su salud. Muchas veces no disponende transporte a las clínicas o al médico. La falta de personal bilingüe y bicultural en el área de la salud impide aun más a los hispanos el acceso al cuidado médico.

Vivienda: Solamente un 9.7% de los ancianos hispanos vive con sus familiares. Pocos pueden depender de la familia para ayuda económica, porque la familia es generalmente pobre tambien. La situación agobiante de pobreza de los ancianos les impide obtener viviendas debido al alto costo de estas. Pocos de nuestros ancianos reciben subsidios de vivienda, y los que las reciben sufren interminables esperas y descriminación al solicitar tales viviendas. Y muchos prefieren permanecer en su casa aunque necesite reparaciones a moverse a un ambiente nuevo y desconocido. Necesitan servicios de restauración y apoyo monetario para mantener sus hogares.

Transporte: La mayoría de los ancianos hispanos dependen del transporte publico, de amigos o familiares para transportarse. El transporte inadecuado es un problema clave, encadenado a servicios de salud, empleo, crimen, nutrición y otros temas. Dos aspectos principales de la dificultad del transporte son: (1) la infrequencia del transporte (sobretodo en las areas rurales) y (2) maneras de transporte que no proveen acceso fácil a los autobuses en vista de las características especiales de los ancianos (por ejemplo, la dificultad de subir las altas gradas de los autobuses). La falta de transporte de emergencia para las necesidades de salud, tiende a aislar al anciano hispano, aumentando aun más su problema de salud.

Idioma: En un estudio de personas mayores hispanos realizado recientemente, el 86% de los entrevistados prefirieron la entrevista en español. El español es claramente el idioma preferido de este grupo, y es muchas veces el único idioma en que se comunican. La falta de personal bilingüe, la falta de formas y información en español, impide a las personas mayores hispanos en el uso de servicios necesarios. Es obvio, que hay que aumentar servicios y personal que sean bilingüe y bicultural.

Crimen: Asaltos, tiroteos, amenazas y vandalismo mantienen a muchas personas mayores hispanas aislados y enserrados en sus hogares. El miedo al crimen, la barrera del idioma, ingresos insuficientes y falta de transporte, significa para muchas personas mayores hispanas una vida solitaria. Los ancianos hispanos piden programas de prevención del crimen que lleven en consideración sus necesidades.

Asistencia legal: Existe una escasez de servicios legales para las personas mayores hispanas. Esta asistencia es necesaria especialmente en asuntos del consumidor tales como disputas sobre alquileres. Los derechos legales y civiles de la persona mayor, son importantes. Ellos tienen derecho a servicios legales para proteger estos derechos.

Nutrición: Los centros de nutrición están lejos de los vecindarios hispanos, y no sirven comidas étnicas. Hay necesidad de crear centros de nutrición para las personas mayores hispanas. Estos centros deberían de proveer servicios sensibles a la cultura hispana. Muchas personas mayores califican como inadecuado el programa de estampillas de alimentos, aunque muchos lo utilizan. El gobierno debe de considerar alternativos de alimentos subsidiarios que puedan servir a los ancianos hispanos.

Empleo: La falta de participación de hispanos en el Seguro Social exige a las personas mayores hispanas que sigan trabajando después de haber alcanzado su edad de retiro. Muchos trabajan como obreros, lo cual no les permite acumular suficientes beneficios de Seguro Social. La persona mayor hispana, se encuentra sin ayuda económica, y sin oportunidad de empleo. Después de haber participado en un vida de trabajo muchas personas mayores se encuentran con problemas de salud, que impiden el seguir trabajando. Es necesario que el gobierno aumente programas de empleo, para personas mayores, en donde la persona pueda brindar un servicio a su comunidad.

Preocupaciones rurales: Mientras la mayoría de ancianos cubanos y puertorriqueños residen en las ciudades, un gran porcentaje de mexico-americanos y otros ancianos hispanos viven en áreas rurales. Las necesidades de mantenimiento de ingresos, empleo, transportación y salud son especiales. Estas necesidades se aumentan con el aislamiento rural y los problemas de la vida campesina. Los pocos recursos económicos, y el trabajo duro del campesino, requieren programas especiales para la persona mayor rural.

Organizaciones de la vejez: Las personas mayores hispanas explican claramente la necesidad de tener legislación que enfoque las necesidades especiales de las personas hispanas. Hablan también de la obligación que tienen los programas de servicios sociales de proveer estos servicios en español, y de la necesidad de personal bilingüe y bicultural. Las personas mayores hispanas piden sus derechos para participar en todos los niveles de los programas para personas mayores.

Las recomendaciones

Las páginas siguientes son un resumen de muchas recomendaciones hechas en los foros regionales y en la Mini-Conferencia Nacional sobre la Vejez Hispana. Las recomendaciones están organizadas bajo seis temas. Este resumen se puede utilizar como una base para desarrollar pólizas y programas para el mejoramiento de la vida de todas las personas mayores.

I. Economía

A. Ingresos

1) Se recomienda que la edad para recibir Seguro Social (65) no se cambie. Si se aumenta la edad a 68, muchos ancianos hispanos serán excluídos del programa porque se envejecen a una edad más joven que la población en general.

2) Se debe aumentar a $7,000 lo que una persona puede ganar, mientras recibe Seguro Social. De este modo los ancianos hispanos pueden aumentar sus ingresos económicos sin perjudicar sus pagos del Seguro Social.

3) El gobierno federal debe de investigar porque pocos ancianos hispanos reciben beneficios del Seguro Social, y así promover que más personas hispanas sean eligibles para Seguro Social.

4) Los estados deben enmendar sus leyes para que no se bajen los pagos de "asistencia a los ancianos" ("Old Age Assistance") cuando se aumentan los beneficios del Seguro Social.

5) Todos los documentos y papeles de información que tratan con el Seguro Social y otras comunicaciones a individuos, deben de estar publicados en español.

6) Las oficians de asistencia económica deben de emplear a más personas bilingües y biculturales en regiones donde viven muchos hispanos.

7) La Administración del Seguro Social debe llevar a cabo un censo sobre los hispanos que reciben el Seguro Social. Realizado este censo, se debe de proyectar el número y las características de los hispanos que recibirán Seguro Social en los próximos 10 años.

B. Empleo

1) El Congreso debe seguir manteniendo el Programa de Empleo de Personas Mayores en Servicio a la Comunidad (SCSEP) bajo el Título V. Además, el Congreso debe requerir que se aumente la participación de personas mayores minoritarias en este programa.

2) Las regulaciones de CETA deben crear programas para emplear a los trabajadores ancianos hispanos actualmente desempleados.

3) El gobierno federal, por miedo de OSHA, debe exigir que todas las señales o rotulos que indican peligros industriales (por ejemplo "Peligro," "Inflamable," "Prohibida la Entrada," etc.) esten escritos en inglés y en español.

4) El gobierno federal debe estimular a los administradores publicos y privados de los programas de CETA, para que estos empleen y den entrenamiento a personas mayores hispanas, con el fin de que estas personas mayores desarrollen programas bilingues sobre medidas de seguridad en el trabajo. Tambien, se debe evitar la explotación cuando se establecen salarios y pagos por trabajo voluntario para las personas mayores hispanas.

II. Salud Fisica y Mental

A. Medicare

1) Los pagos de Medicare deben incluir el costo de servicios de prevención y de mantenimiento de la salud. Los pagos para servicios medicos en casa deben aumentarse.

2) Los pagos de Medicare deben ser aumentados para incluir el costo de drogas recetadas fuera del hospital; examenes de los ojos y lentes; aparatos para oir bien; examenes dentales y dientes postizos; servicios medicos para convalecencía despues de una enfermedad grave; examenes fisicos rutinarios; y servicios de salud mental en casa.

B. Servicios Para Mantener la Salud

1) Se debe nombrar a ancianos hispanos como miembros de juntos que planifican y administran sistemas de servicios comprensivos de salud a nivel nacional, estatal, y local.

2) Se deben llevar a cabo investigaciones y programas sobre los medios informales de mantener la salud de los ancianos hispanos.Para mantener la salud fisica y mental, se deben de establecer programas que promueven medios informales de asistencia, en lugar de crear más instituciones.

3) La eligibilidad para servicios para mantener la salud no debe basarse en la edad cronologica sino en la incapacidad de la persona mayor para mantenerse.

4) Se debe emplear a más profesionales bilingues/biculturales en el campo de la salud para proveer servicios a las personas mayores hispanas. Los programas medicos de entrenamiento deben enfocarse sobre las necesidades medicas especiales de los ancianos hispanos. Tambien se deben entrenar a las personas mayores como para-profesionales que pueden proveer servicios medicos a otras personas mayores.

C. Nutrición

1) Se deben de establecer programas de educación en nutrición para las personas mayores hispanas y para los que proveen servicios de nutrición. Estos programas deben enfocarse sobre la planificación de comidas nutritivas que reflejan las preferencias étnicas de los cubanos, los mexico-americanos, los puertorriqueños, y los centro- y sudamericanos.

2) El programa de estampillas de alimentación debe de ser mejorada para que más de las personas mayores hispanas pobres puedan obtenerlas. Hay que establecer medios para mejorar las satisfacción de los clientes con esta programa.

III. Bienestar Social

A. Vivienda

1) La planificación de vivienda debe ayudar a las personas mayores hispanas para que éstos se mantengan en su propia casa y vecindario. Las personas mayores hispanas deben recibir beneficios que las ayudan a pagar la renta y mantener la casa.

2) El Congreso debe promover legislación especial sobre la vivienda, que provee fondos para la renovación de viviendas en vecindarios hispanos.

3) El gobierno federal debe continuar la asistencia a los estados y gobiernos locales, para que sigan programas de renovación de vivienda para las personas mayores. Además de esta asistencia, se deben aumentar los fondos para proyectos que asisten a las personas mayores a permanecer en sus hogares. Los programas como CETA y servicios comunitarios, se deben de usar en estos proyectos de renovación.

4) El Departamento de Vivienda y Desarrollo Urbano, y el Dept. de Salud y Servicios Humanos, deben de trabajar juntos, para eliminar regulaciones, y obstáculos fiscales, que impiden el desarrollo de proyectos de vivienda que incluyen arquitectura sensible a la cultura hispana.

5) El gobierno debe estimular la construcción de viviendas no costosas para las personas mayores hispanas.

B. Transporte

1) Se debe establecer programas de transporte para emergencias que estén disponibles día y noche y que utilicen personal bilingüe y bicultural. Estos programas deben de funcionar en áreas rurales tanto como urbanas.

2) Los comités para planificar el transporte deben incluir miembros de diversas razas y edades, por ejemplo las personas mayores hispanas.

3) El gobierno federal debe de estimular a los sistemas de transporte rural para que éstos establezcan programas para las personas mayores hispanas.

C. Ley y Justicia

1) Se debe de crear un comité "anti-crimen" cuyos miembros incluyen a policías hispanos. Estos policías deben entrenar a las personas mayores hispanas sobre los modos de evitar el crimen.

2) Deben de establecerse programas bilingües para ayudar a los víctimas de crimen. Los gobiernos estatales y locales deben de desarrollar estos programas.

3) Se deben de desarrollar programas bilingües para proveer ayuda legal por teléfono. Estos programas deben de incluir cintas bilingües, que se pueden escuchar por teléfono, sobre la prevención del crimen, derechos de inquilinos, etc.

D. Educación

1) Los centros de gerontología deben establecer programas educativos que se enfoquen en la cultura y necesidades especiales de los ancianos hispanos.

2) Programas educativos en español enfocados en problemas de la vejez, pre-retiro, y servicios sociales, deben ser desarrollados y transmitidos por todos los medios de comunicación.

E. Idioma

1) El uso de personal bilingüe/bicultural debe de ser obligatorio en los programas de servicio social para personas mayores hispanas.

2) Los medios de comunicación en español se deben de usar para proveer información sobre programas de asistencia social a las personas mayores hispanas.

IV. Investigación

1) Las organizaciones sobre la vejez y las universidades con programas de gerontología deben de identificar, entrenar y promover el desarrollo de personal hispano.

2) Se debe de estudiar la relación entre la edad cronológica y la edad funcional en las personas mayores hispanas. Estos estudios pueden ayudar a crear programas que sirven a la persona, desde el punto de vista funcional en lugar de edad cronológica.

3) Hacer análisis demográficos profundos de el censo de 1980 para modificar y expander servicios a las personas mayores hispanas.

4) Todas las entidades del gobierno relacionadas con la vejez deben de separar fondos de investigación para el desarrollo de más investigaciones sobre la vejez minoritaria.

V. Movimientos para la Vejez/Legislación

1. La Administración para la Ancianidad (AoA) y las organizaciones para personas mayores de grupos minoritarios, deben desarrollar una póliza nacional para servir a estas personas mayores de minoría. La "AoA" debe de asegurar que las agencias estatales y locales que sirven a las personas mayores se conformen a la póliza nacional.

2) Todas las agencias estatales y locales que sirven a personas mayores hispanas deben de emplear suficiente personal bilingüe y bicultural, sobre todo en áreas donde viven muchos hispanos.

3) Se deben de crear programas para entrenar a personas de minoría como profesionales en el campo de la gerontología.

4) El Acto para Ancianos Americanos ("OAA") debe volver a nombrar a las personas mayores de minoría como un grupo principal para recibir servicios bajo el "OAA."

5) La "OAA" debe de exigir que las agencias estatales y locales sobre la vejez provean servicios en la propia lengua de sus clientes que no hablan inglés.

VI. El Bienestar Cultural y Espiritual

1) La soledad, el aislamiento, y la moral son preocupaciones principales para las personas mayores hispanas. Los que proveen servicios a este grupo deben de ser sensibles a las necesidades de las personas mayores hispanas con respecto a las necesidades de salud mental.

2) Todos los programas que sirven a las personas mayores hispanas deben tomar en consideración las necesidades culturales específicas de cada grupo hispano: cubanos, mexico-americanos, puertorriqueños, y otros hispanos.

3) Las iglesias y otras instituciones religiosas deben de establecer programas que apoyan a las personas mayores de minoría. La iglesia tiene responsibilidad por el bienestar espiritual de estas personas, ya que la importancia de la iglesia en la vida de los hispanos mayores está bien documentada.

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the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on the Environment and Older Americans

MCR-26

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

ENVIRONMENTAL ISSUES

National Retired Teachers Association and
the American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20049

Washington, D.C.
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Environment & Older Americans

PREFACE

In February, 1981, the National Retired Teachers Association and the American Association of Retired Persons convened a Mini-Conference on the Environment and Older Americans. The meeting, held in Washington, D.C., developed recommendations about three areas in which environmental and elderly interests coverage: Health Impact, Employment and Volunteer Opportunities, and Advocacy and Consumer Participation. Over thirty-five experts from around the country discussed these topics in three workshops. Participants included representatives from such federal agencies as the Environmental Protection Agency and the Department of Housing and Urban Development; from organizations representing the aging such as the National Institute on Aging, the National Caucus and Center on Black Aged, and the National Council on the Aging; and from institutions of learning such as George Washington University, Boston University, and the University of Michigan. These are some of their major recommendations:

- Improve environmental information and eduction to include identification of conditions and products harmful to the elderly.
- Reduce the elderly's exposure to environmental hazards.
- Use data from the National Death Index in combination with other data sets to provide information about life-long environmental exposure.
- Develop emergency procedures for environmental alerts.
- Support enabling legislation for the Senior Environmental Employment (SEE) program.
- Create formal and on-the-job training programs for older workers in environmental occupations.
- Create tax incentives for hiring older workers, job-sharing, and expenses-paid volunteer programs.
- Develop flexible income/age guidelines to remove restrictions on hiring older workers.

- Sponsor research through Department of Housing and Urban Development and Administration on Aging to evaluate public and private housing for the elderly in terms of protection from environmental health hazards.

- Increase the representation of the elderly, particularly low-income, minority and rural populations, in the decision-making on environmental projects and regulations.

The recommendations in this report represent the concensus of opinions of the delegates participating in the mini-conference and do not necessarily reflect the views of NRTA-AARP, the convening organization, or the government agency that funded the project.

The meeting was jointly funded by NRTA-AARP and the U.S. Environmental Protection Agency.

INTRODUCTION

In November, 1981, the White House Conference on Aging will convene to develop an agenda for aging policies and programs for the 1980's. Of the issues to be discussed, few are more important than the environment. Environmental pollutants adversely affect the health of the elderly. At the same time, the field of environmental regulation and control offers older Americans a variety of employment, volunteer, and advocacy opportunities.

HEALTH IMPACT

Americans are healthier and are living longer than ever before. At the same time, many Americans have become aware of the threat of environmental pollution to human health. Various chemicals in our air and water, radiation hazards, and noise are among dozens of environmental pollutants that can harm life. Older people especially have cause for concern because the cumulative effects of aging make the elderly more susceptible to environmental hazards. Although the younger population suffers from the same maladies that affect the aged, older people tend to have more chronic ailments and less immunity to disease than younger people. The elderly's illnesses last longer, and the elderly may be more likely to exhibit cumulative effects of long-time exposure to toxic agents. Toxic compounds can produce cancer, neurological and behavioral impairments, chronic degenerative diseases, and other disorders.

Among environmental hazards that affect the elderly are chemicals such as kepone, PCB's and PBB's that contaminate our waterways, sulfur oxides, carbon monoxide, photochemical oxidants and nitrogen oxides that pollute our air, and asbestos, once considered to be only an occupational hazard but now known to be a potential hazard to us all.

It takes a long time to discover the impact of pollutants upon health. The Surgeon General stated that the effects of some compounds in use today may not be known until the twenty-first century.[1] Thus, many of our nation's youth may face crippling disabilities or ill health in their middle or later years. Certainly, the findings of longitudinal research must be studied and applied, and much more research in environmental hazards is needed.

Resolution Topic: Improved Environmental Information and Education

Description of Problem:

Consumers do not have access to adequate age-specific information about conditions or products that might be hazardous to their health. They do not know where to go for information or how to report hazards.

Statement of Recommendation: Therefore be it resolved that:

1. Certain public and private agencies should be identified as having lead responsibility for developing and implementing educational programs. These programs should:

- Identify hazardous products and conditions;
- Educate targeted populations about risks; and
- Train service providers.

2. The public should be given information about the specific agencies and programs that deal with environmental hazards and the elderly.

Resolution Topic: Reduction of Exposure to Environmental Hazards

Description of Problem:

The public health is constantly being threatened by exposure to pesticides; excessive noise; and harmful chemicals in soil, air, water, building materials, and food. There also are hazardous materials in appliances and other consumer products.

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[1] Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention, Washington, D.C., 1980.

Statement of Recommendation: Therefore be it resolved that:

1. Hazards should be identified, and the public's exposure regulated by Federal and state laws.

2. Current standards of chronic low-dose radiation should be reexamined periodically, and appropriate research conducted, particuarly with regard to fission products and their effects upon older people.

Resolution Topic: Use of National Death Index

Description of Problem:

Data are available but are underutilized concerning knowledge of specific environmental risks and their health implications.

Statement of Recommendation: Therefore be it resolved that:

The National Death Index provides data on the causes of death. This data set, in combination with data sets from the U.S. Health Care Financing Administration, U.S. Social Security Administration, and the Internal Revenue Service should be used to assess the relationship between lifelong environmental exposure and cause of death. Appropriate safeguards must be incorporated to protect the individual privacy of each subject.

An appropriate agency should be designated (or if no agency is available, it should establish one) as having access to key data sets. This agency should work closely with other agencies responsible for continued surveillance of acute and continuous hazards that impact on disease, discomfort, and quality of life.

Resolution Topic: Emergency Procedures in Environmental Alerts

Description of Problem:

There are few effective, standardized emergency procedures regarding various classes of serious life- or health-threatening conditions, ranging from smog to nuclear accidents. Depending upon the contacted agency, region of the country, and population concerned, procedures range from overreaction to no action at all in regard to the same kind of situation or condition.

Statement of Recommendation: Therefore be it resolved that:

1. Appropriate public agencies should undertake to identify, in a systematic way, the range of life- or health-threatening conditions, with particular attention to the more vulnerable population groups.

2. The most appropriate procedures in response to the said conditions should be tested and standardized.

3. Agencies with responsibility of procedures implementation should be designated.

Resolution Topic: Research on Environmental Factors that Influence Aging

Description of Problem:

We really do not know why people age at different rates. It is possible that environmental factors, such as infections, drugs, certain kinds of stress, heavy metals, and pollutants, acting individually or synergistically, influence aging. Their effects on the mutation, rearrangement, and repair of DNA, detoxification, and late development may alter the rate of aging.

Statement of Recommendation: Therefore be it resolved that:

1. The concerned Federal agencies, including Environmental Protection Agency and National Institutes of Health, as well as the pharmaceutical industry, should increase support for research on the cause and progression of aging and on controllable environmental factors that can improve the health and longevity of older persons.

2. Support for research in genetics, biochemistry, toxicology, and epidemiology should be expanded.

Minority Report of Resolution Topic: Use of Environmental Planning and Design to Foster the Elderly's Independence

Description of Problem:

Many features of our human-made environment, including equipment, tools, appliances, living arrangements, and health care arrangements foster dependency on the part of older persons. Environmental planning and design should enhance physical and mental health and promote self-reliance and independence.

Statement of Recommendation: Therefore be it resolved that:

1. Consumer panels that include older people should evaluate equipment of all kinds.

2. Designers of living and working environments and manufacturers of appliances should be trained in the elderly's needs.

3. Health care polices that promote independence should be established and enforced.

4. A national panel should be established to develop broad guidelines regarding the design of environments that promote independence.

EMPLOYMENT AND VOLUNTEER OPPORTUNITIES

The enforcement of standards of quality of air, water, and land resources requires a growing corp of technicians trained to deal with mounting environmental problems. Yet, many concerned government agencies are faced with a dilemma: the need for more staff and the lack of funds to hire personnel. Older people, if utilized as volunteer or paid workers, might be of great assistance.

The aged are America's fastest-growing minority. One in every nine persons in the U.S. is sixty-five years of age or older. These twenty-three million men and women comprise about eleven percent of the total population. Despite the stereotype that depicts the elderly as uninvolved, docile, and bored, approximately twenty-two percent of the older population do volunteer work in their communities. And over thirteen percent were in the labor force as of November, 1979.

Recognizing this potential of older persons as workers, EPA and the Administration on Aging signed an interagency agreement in the mid-1970's to fund a series of model projects that were designed to demonstrate how older people could be used in environment-related programs. Thus, in 1977, the Senior Enviornmental Employment (SEE) program was created to develop training materials and designs. Its pilot phase demonstrated that older people were willing to become involved and were capable of performing a wide variety of surveying, monitoring, and training activities related to air quality maintenance, water supply control, hazardous waste management, pesticide usage, and solid waste projects assistance. The Congressional Appropriations Committee directed the Department of Labor to work with EPA to fund the SEE Corps. To date, however, the two agencies have not entered an agreement.

In the last session of Congress, Senator Culver introduced legislation that sought to make permanent and expand the SEE program, but the bill failed to emerge from Committee. Senator Chafee will introduce a similar bill in the current session.

Resolution Topic: Enabling Legislation for a Senior Environmental Employment (SEE) Program

Description of Problem:

After two years of testing, the Environmental Protection Agency and the Administration on Aging have determined that the SEE program is a success, but the absence of enabling legislation prevents full attainment of the SEE program's potential for both enriching the lives of older Americans and contributing to the public welare by employing elders in environmental abatement and control occupations.

Statement of Recommendation: Therefore be it resolved that:

1. The Senior Environmental Employment program should be established permanently to assist older workers in overcoming barriers to environmental employment.

2. The Federal agency responsible for the program should award contracts, and grants to enter cooperative agreements with state and local governments, institutes of higher learning, and organizations with aging or environmental interests.

3. The administering agency should also be authorized to accept funds from other governmental or non-governmental sources without having its federal appropriations reduced.

4. The administering agency should further be authorized to draft rules that will not restrict participation because of income.

Resolution Topic: Creating Environmental Job Opportunities and Training Programs

Description of Problem:

Opportunity for useful employment in environmental occupations is generally unavailable to qualified retired older persons. In addition, lack of training in technical or semi-technical fields prevents many older individuals from participating.

Statement of Recommendation: Therefore be it resolved that:

1. Regional, state, and local environmental agencies should develop on-the-job and other formal training programs for older persons.

2. Portions of Federally-provided administrative program funds should be earmarked for jobs for older workers in environmental fields.

3. Grant programs should be developed to provide training and second career opportunities in environmental education and public participation.

4. State and Federal governments should develop tax incentive programs for the hiring and training of older workers for environmental occupations in private industry.

5. Training programs should be designed to utilize the skills of the older worker to train incoming staff of environmental agencies.

Resolution Topic: New Options for the Elderly in the Environmental Field

Description of Problem:

Because both protection of the environment and employment of the elderly only are recently acknowledged societal needs, information on how to deal with these needs is inadequate.

Statement of Recommendation: Therefore be it resolved that:

The federal government and other public and private resources should be directed to study and experiment with the following options:

1. Innovative on-the-job environmental training activities;

2. Creative intergenerational environmental support programs;

3. Job-sharing for environmental jobs;

4. Expenses-paid volunteer programs in environmental fields;

5. Pre-retirement training programs for industrial personnel that could facilitate transition to environmental jobs;

6. Employer awareness programs that show the benefits of hiring the older person;

7. The use of older persons in public education programs, thereby using their skills and general credibility to enlist the support of industry and the public for a responsible approach to the use of the natural resources; and

8. Development of a series of jobs in which risks might be more properly borne by older workers, i.e., jobs that entail possible genetic damage to the worker.

Minority Opinion:

A lively discussion was held in the plenary session about Resolution 8 and several delegates, including some from the national aging organizations, felt that the resolution implied that older persons are second class citizens, and not as useful as younger people. One physician noted that in the case of exposure to nuclear radiation, all body cells, not just those of the reproductive organs, may be damaged. However, the drafters of this Resolution felt that older people should have the option of offering to volunteer for difficult or dangerous work, thereby sparing risk to younger people. The drafters also pointed out that the recommendation was meant to encourage research into the advisability of such use of older volunteers and the development of a list of appropriate jobs.

Resolution Topic: Flexible Income/Age Guidelines

Description of Problem:

There are many environment-related jobs that are suitable for older persons who have certain technical backgrounds or expertise, but it is not always possible to recruit qualified candidates who meet existing income guidelines. Many income guidelines are unnecessarily restrictive, and there are many needy people whose incomes are above the guideline criteria.

Many states are bound by merit system regulations that require that all regular employees receive the same benefits. This precludes the hiring of workers over age 70 because their age renders them ineligible for membership in the pension system.

Statement of Recommendation: Therefore be it resolved that:

1. When filling positions funded under the Senior Environmental Employment program, preference should be given to qualified poverty level applicants, but other aspects of "need" also should be considered.

2. Legislation should be enacted that relaxes state merit system position requirements that stipulate program participants must be eligible for membership in the pension system.

ADVOCACY AND CONSUMER PARTICIPATION

An individual can participate in the government's decision-making process in a number of ways--by voting, petitioning, campaigning, and speaking at public hearings, to name only a few.

The growth of citizen participation programs over the past two decades has been especially evident in federal programs and administrative activities. Strategies and programs to involve the public directly in administrative procedures during policy planning have multiplied. Several acts, notably, the Clean Air Amendments of 1970, Noise Control Act of 1972, and Safe Drinking Water Act of 1974 recognize citizen rights to sue public agencies or numerous private interests to force compliance with regulatory programs.

President Carter further strengthened the Federal government's commitment to citizen participation through Executive Order 12160, the "Consumer Executive Order." The order became effective in July, 1980, and calls for "the enhancement and coordination of Federal consumer programs and early and meaningful participation by consumers in the development and review of all agency rules, policies, and programs." In addition, the agencies are mandated to produce and distribute materials that inform consumers about agency responsibilities and services, agency procedures for consumer participation and aspects of the marketplace for which the agencies have responsibility.

The Environmental Protection Agency published new Guidelines on Public Participation in January, 1981, reaffirming its intention to involve the public in its decision-making activities and detailing programs for such involvement.

The EPA has also recognized that there is a need for educating older persons about fundamental environmental issues. To this end, it has funded the Gray Panthers, an activist group representing the interests of older persons, to develop and implement an Environmental Awareness Project. The project will help older people take a more active role in citizen participation programs.

The National Retired Teachers Association-American Association of Retired Persons, which represents twelve million older people, also instituted a major citizen representation project. The project will build up, in numbers and effectiveness, the force of older consumers serving on decision-making bodies at all levels of government and in the private sector.

Citizen participation must take many forms to fully impact America's environment. Key decisions about environmental health and employment are made daily by business and industry. Older citizens should be advocating that their interests be included in those decisions wherever possible. Additionally, aging organizations and other public interest groups that have substantial influence should be encouraged to speak more forcefully on issues affecting the environment and aging Americans.

Resolution Topic: Dissemination of Existing Data on Environmental Hazards and the Elderly

Description of Problem:

The public needs better access to data about the differential impact of various kinds of pollution and environmental hazards upon the elderly (e.g., do older people suffer more from air pollution than other adults, or more from ground water contamination in rural areas?) and the specific needs and desires of the elderly for various components of a quality living environment (e.g. what kinds of housing and neighborhood environments are most desired or used?). Decision-makers in government and the private sector often do not realize the impact of their actions upon the elderly. The elderly find it difficult to advocate their own interests because of the lack of accurate supporting data.

Statement of Recommendation: Therefore be it resolved that:

1. The National Institute of Aging or other appropriate agencies should compile a summary, based upon existing data, of the chief environmental health hazards affecting the elderly. The summary should be written in layperson's terms. At the same time, data gaps should be identified.

2. The Administration on Aging (AoA) should send this summary to all Area Agencies on Aging and to the libraries of all gerontological and architectural schools.

3. The Environmental Protection Agency should send this summary to its list of consumer and environmental groups.

4. The Department of Housing and Urban Development (HUD) should sponsor sessions that utilize this summary at national conferences of builders and architects, and with city and county organizations that make decisions that directly or indirectly affect the quality of the housing environment.

5. The Veterans Administration and the Farmers Home Administration should share the summary with those who participate in their housing programs.

6. HUD and the AoA should sponsor research that evaluates public and private housing for the elderly in terms of protection from environmental health hazards and positive quality of life.

7. Specific funds should be appropriated to carry out Item 6 and and to research the data gaps identified in Item 1.

Resolution Topic: Need for National Program on Environmental Change and Adaptation

Description of Problem:

Society bears a heavy responsibility for the well-being of one of our country's greatest resources -- its older people -- and yet does not always have adequate information about environmental changes as they affect the elderly.

Statement of Recommendation: Therefore be it resolved that:

1. Congress should mandate that the Environmental Protection Agency, in conjunction with the Department of Education and the Administration on Aging and other federal agencies involved directly and indirectly with programs at the national, state, and local levels, implement a basic, national environmental education program.

2. Such a program should include procedures for the development of an early warning system that will inform older citizens of potential environmental hazards and provide specific instructions and resource materials about self-help and a wide range of protective or adaptive measures.

3. Decision makers at national, state, and local levels should be required to consider the potentially harmful impact of environmental change, including environmental impact of plans upon the elderly.

4. Special educational programs and mechanisms should be developed to ensure that the physically and mentally handicapped, those persons who speak languages other than English, and those persons who live in rural areas have adequate opportunities to participate in environmental education programs.

Resolution Topic: Funding Need

Description of Problem:

Funding sources are needed to help implement public awareness and education programs that are directed to the needs of the elderly.

Statement of Recommendation: Therefore be it resolved that:

1. The Environmental Protection Agency should increase funding to state environmental agencies to help them expand or implement public awareness and education programs that address issues with major impact upon the elderly, and seek greater involvement of the elderly in state environmental programs. There must be an increase in available funds, not just a redirection of existing program funds, to make the program work.

2. The Department of Labor, in cooperation with the Environmental Protection Agency, should urge the funding of a permanent and expanded Senior Environmental Employment Program to be modeled closely on the SEE model program administered by the Administration on Aging and the EPA. This program could provide direct program grants to the states to employ senior citizens in environment-related programs, including programs that provide environmental education to other senior citizens.

Resolution Topic: Proportional Representation for the Elderly

Description of Problem:

The elderly, and particularly those who are low-income, minorities, or rural-dwelling, are consistently underrepresented in the environmental decision-making process. Seniors have been ignored by the power structure and they themselves often fail to address environmental issues.

Statement of Recommendation: Therefore be it resolved that:

Federal, state, and local governments and the private sector should stimulate interest and provide access by senior citizens to the environment decision-making process, proportional to the elderly's representation in the population at large, by establishing outreach programs to ensure the inclusion of represenatives from aging advocacy organizations on advisory committees, task forces, hearings, and in all phases of the regulation development process. Special emphasis should be required to recruit representatives from low-income, minority, and rural groups.

Resolution Topic: Developing a Network of Environmental Agencies, Private Enterprise, and Aging Organizations

Description of Problem:

Because of the lack of an established network of environmental agencies, private enterprise, and aging organizations, important information on environmental problems is not disseminated, opportunities for cooperative solutions to environmental problems do not exist, and combined efforts to express public sentiment to decision makers are not realized.

Statement of Recommendation: Therefore be it resolved that:

1. A network of environmental agencies, private agencies, private enterprise, and aging organizations should be established to alert older people to potential and existing problems affecting their health and welfare.

2. The network should express public sentiment on environmental issues to decision makers for the purpose of developing environmental policy, and should tackle local environmental issues.

Follow-up

Additional information about the Environment and Older Americans Mini-Conference is available by contacting: Program Development Section, NRTA-AARP Program Department, 1909 K Street, N.W., Washington, D.C 20049.

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on
Aging

Report of the Mini-Conference on Alzheimer's Disease

MCR-27

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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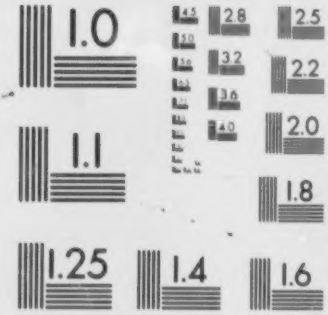
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MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS
STANDARD REFERENCE MATERIAL 1010a
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MINI-CONFERENCE CONVENOR

Alzheimer's Disease

This conference was sponsored by the Alzheimer's Disease and Related Disorders Association (ADRDA) in cooperation with the National Institute on Aging, the National Institute of Neurological and Communicative Disorders and Stroke, and the National Institute of Mental Health. Two hundred persons attended this conference, including representatives of the ADRDA Chapters, Board members, interested family members and professionals.

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Albert Einstein College of Medicine

Stanley Appel, M.D.
Baylor College of Medicine

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University of Colorado

Frank Benson, M.D.
University of California, Los Angeles

John Blass, M.D.
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Bruce Schoenberg, M.D.
Neuroepidemiology, NINCDS

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Albert Einstein College of Medicine

Bronx, New York
September 28, 1980

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ALZHEIMER'S DISEASE, A KILLER OF HOPE (Isaiah Ehrlich)

Alzheimer's disease, more than three quarters of a century after it was recognized, remains an essentially unknown, untreated affliction. It strikes in almost unnoticeable ways so that its onset is not recognized early by its victims or their families. It is a progressive disease, inexorable in its development from early loss of memory, followed by speech difficulty, then disorientation at simple tasks, and finally, seemingly irrational behavior. It is ruthless in its democracy. It ignores class lines and affects rich and poor alike. In its progress it destroys not only the afflicted individuals but also those near and dear to them.

Affecting mainly people at or past middle age, it destroys what should be "the golden years" for untold numbers. It is a scourge for the aging. Demographic estimates place the number of Americans now suffering from the disease at up to one and a half million. The actual total may be several times that number. Considering the impact on family members; spouses, brothers and sisters, children, the number of Americans affected at any time probably runs to the tens of millions.

In the face of the enormity of this problem little has been done to identify this most common cause of intellectual impairment, nor to find an effective treatment. A massive, concerted drive to determine the causes of this disease must be part of the program for action of older Americans. We must insist that adequate funds, which we in our most productive years helped accumulate, be assigned to identify this scourge and to find a cure, or at least, ameliorative treatment.

Resolution adopted at
Mini-White House Conference
on Aging,
Bronx, New York,
September 28, 1980.

IDENTIFYING DEMENTING ILLNESS

Epidemiology (Bruce Schoenberg, M.D.)

Although dementia has long been recognized as a common clinical problem among the elderly, the difficulties inherent in studying Alzheimer's disease have, until recently, hampered epidemiologic investigations of this condition in the U.S. Despite these problems, rapid progress is being made in the epidemiologic study of dementia and Alzheimer's disease. The only currently available tabulations concerning the incidence of dementia in a U.S. population are derived from a study of residents of Rochester, Minnesota yielding an average annual incidence rate of 110 new cases per 100,000 population per year. These incidence figures are probably underestimates of the true magnitude of this major health problem. Of the 102 identified patients, 77 required permanent institutional care. The median time from onset to institutionalization was 8 months. The median survival was 58 months. Other studies have reported a shortened survival among demented patients compared to age-matched controls. Such data are not based on all cases in a defined population and may suffer from selection bias. If these observations are confirmed by population-based studies, the causes of excess mortality among the demented individuals will need to be explained. The age-specific incidence rates for all dementias and for the subgroup thought to represent Alzheimer's disease show an increase with increasing age. In addition, the incidence rate for the cases diagnosed as Alzheimer's disease was greater for women than for men. Analytic epidemiologic studies have recently demonstrated an excess of Down's syndrome and hematologic malignancies in the relatives of probands with histologically verified Alzheimer's disease. Moveover, Down's syndrome patients surviving into their third decade demonstrate the neuropathologic features characterizing Alzheimer's disease. This relationship is being explored through more intensive investigations. Studies are also underway to measure the prevalence of dementia in defined populations according to ethnic group and race. The identification of individuals at particularly high or low risk for dementia should provide valuable etiologic clues.

Vascular Dementia (Robert Katzman, M.D.)

There are over fifty diseases that present as dementia; Alzheimer's disease accounts for over half of the cases of dementia, vascular disease 20 to 25%, 20% being due to the remaining disorders. Twenty years ago, most older individuals with serious memory loss and other symptoms of dementia were said to have "cerebral arteriosclerosis", "hardening of the arteries". Today we know that Alzheimer's disease is the predominant cause of dementia. Nevertheless, there is a significant number of individuals in the United States, somewhere between 300,000 and 700,000 persons, afflicted by dementia secondary to multiple strokes resulting from vascular disease (multi-infarct dementia). This number is especially important because much is now known about risk factors for heart disease and stroke; further understanding of these risk factors and early diagnosis of multi-infarct dementia might enable us to prevent the occurrence or progression of this disorder.

When multi-infarct dementia is diagnosed or suspected a cause of the disorder should be sought. Hypertension is the most important risk factor in strokes. Some cases may be associated with heart disease and irregularities of heart beat. Our recommendation then is the support of research on risk factors: Are the risk factors for multiple stroke the same as for single strokes? When a stroke occurs in an older hypertensive individual, is it safe to lower blood pressure? Will this help prevent further strokes? What is the role of cardiac disorders as risk factors in stroke? Do paroxysmal arrhythmias play a significant role? Should more individuals have pacemakers? Does mitral prolapse contribute to multi-infarct dementia? Further research on the risk factors holds the promise of a significant reduction in the incidence, and perhaps eventual prevention of this important cause of dementia.

Depression and Dementia (Paul McHugh, M.D.)

How can we distinguish those individuals who have depression at the root of their dementia from those who have some other condition? There are some elderly patients in the midst of a depressive episode who are indistinguishable from Alzheimer's disease in the sense that they have a severe impairment of cognition without a change in consciousness or any obvious motor, sensory or reflex change or any specific laboratory data that points to a specific brain disease. We have follow up data on 17 patients followed over two years after an admission to the Hopkins clinic with a depressive disorder with clear cognitive problems. These patients, all improved with treatment. Several had subsequent attacks of affective disorder. Only one subsequently had a deteriorating cognitive course. These patients do have a typical dementia state that is not distinguished from any other dementias on the basis of the cognitive impairment per se. Affective symptoms do accompany the patient's cognitive impairment. Aspects of the history are useful. The major differences from controls are a family history of affective disorder found in 23.5%, a previous attack of depression or mania found in 65%, and a subacute onset of the symptoms. Thus a clinical diagnosis of the dementia syndrome of depression should be considered in all individuals who show, along with an impairment of cognitive capacity, a depressive mood, depressive type delusions, a family history of mania or depression, a previous attack of mania or depression and a recent onset (weeks to months). Yet there are still occasional patients whom this clinical approach to diagnosis misses. This fact calls for efforts to establish objective methods to diagnose depressive psychoses and to diagnose the other brain diseases such as Alzheimer's and "infarct" dementia with which it can be confused.

A CLOSER LOOK AT THE AGING BRAIN

Positron Emission Tomography (Frank Benson, M.D.)

Emission computed tomography is a non-invasive scanning method that produces a cross-sectional image of brain radioactivity following intravenous injection of a radioactive indicator. The imaging process resembles X-ray CT but where X-ray CT shows anatomic structure, emission computed tomography has a potential for measuring blood flow, metabolism and other cerebral functions, dependent upon the labeled compound chosen as a tracer. There is reason to feel that this procedure offers considerable advantage over many of the techniques currently used to study dementia. The PECT technique, utilizing a dynamic, metabolic action, appears ideally suited for research into varieties of dementia. There are patterns characteristic of specific neurological disorders. Patients with Alzheimer's disease showed decreased cortical metabolic rates in comparison to normal controls. In patients with Huntington's disease, no correlation was demonstrated between the amount of cerebral metabolism and the degree of dementia. There appears to be a real but slight decline in cerebral metabolism with advancing age. The decrease does not appear as great in our population as has been reported in an earlier study. While data is only preliminary, there appears to be a tremendous potential for the PECT scan in the study of dementia.

Neurotransmitters and Biochemical Changes (Peter Davies, Ph.D.)

The last five years have seen considerable growth in the numbers of studies of neurotransmitter-related parameters in autopsied brain tissues from cases of Alzheimer's disease. Six independent groups have published papers describing reductions in the activity of choline acetyltransferase (ChAT) in autopsied brain tissue from cases of AD/SDAT. This highly consistent finding provides clear evidence for involvement in AD/SDAT of neurons which produce and release the neurotransmitter acetylcholine (cholinergic neurons). On the other hand, receptors for acetycholine appear to be remarkably well preserved in samples of brains from patients with AD/SDAT: muscarinic receptor concentrations have been found to be normal by three of four groups who have investigated this area. These observations offer hope that restoration or replacement of apparent losses of acetylcholine might be effective because the receptors for this transmitter remain. Up to 1980, only one of five neurotransmitter systems investigated in cases of AD/SDAT showed consistent evidence of abnormality: the cholinergic system. In the past year, two of the more recently discovered peptide neurotransmitter systems have been examined in cases of AD/SDAT. Concentrations of vasoactive intestinal polypeptide (VIP) were found to be normal in cases of AD/SDAT which showed reduced ChAT activity. However, concentrations of somatostatin-like compounds have been shown to be reduced in AD/SDAT cases. In our own study, concentrations of somatostatin-like immunoreactivity (SLI) were significantly reduced in 7 out of 8 cortical regions studied, and strong correlations were found between reductions in SLI and ChAT activity in frontal and temporal cortex. Further efforts must be directed toward asking why certain neuronal systems are selectively affected in AD/SDAT. It seems possible now to use the selective destruction of particular neuronal systems as an assay for whatever agent or process it is that causes AD/SDAT. Efforts in this direction should be vigorously encouraged.

Metabolic Changes (John Blass, M.D.)

As people age, their brains tend to burn sugar and other fuels more slowly, and this decrease in metabolic rate is accentuated in patients with dementias. The excessive decrease may be secondary to the dementia, but it can be related to deficiencies in acetylcholine and other neurotransmitters (the chemicals nerve cells use to communicate with each other). Learning more about the metabolic changes may help in devising ways to break the chain of events that lead to the clinical illness. Most current opinion holds that the demented brain burns less fuel because it is working more slowly, rather than working imperfectly because it is less able to burn fuel. However, mild to moderate impairments of cerebral carbohydrate metabolism do lead to deficiencies in the synthesis of neurotransmitters, including acetylcholine, a compound known to be deficient in Alzheimer disease. Reducing cerebral carbohydrate oxidation proportionally reduces the synthesis of acetylcholine, even though less than 1% of the carbohydrate oxidized is used for acetylcholine synthesis. Impairing brain carbohydrate metabolism also impairs the synthesis of other transmitters, including norepinephrine, L-DOPA, serotonin, and putative amino acid transmitters. Clearly, much more work is needed on how specific neurotransmitters respond to different metabolic derangements.

Experimental Therapies (John Growden, M.D.)

The best treatment for Alzheimer's disease would be its prevention. As a second best remedy, if its etiology were known, preventive measures and specific therapies could be directed against the causes, for example, to chelate metals, suppress viral infections, correct chromosomal abnormalities, or remove abnormal proteins from the brain. For the present, however, treatments are limited to those that compensate for abnormalities that do occur. Cholinergic neurons are selectively affected in the brains of patients with Alzheimer's disease.

Both choline and lecithin administration have already proved useful in the treatment of one neurologic disorder - tardive dyskinesia - which is associated with deficient cholinergic tone, and it was natural to test lecithin in Alzheimer's disease as well. A comparison of lecithin and placebo scores shows that memory-test performance during lecithin ingestion was either the same as or inferior to performance during placebo ingestion in most instances. On verbal paired-associated learning, however, four patients with Alzheimer's disease obtained substantially higher scores while taking lecithin than they did while taking the placebo. In addition, some family members and friends of these patients reported favorable changes in daily behaviors during lecithin ingestion. These findings suggest that the beneficial effect of lecithin treatment might be selective with respect to person and task.

There should be increased public and private support for treatment and research centers as well as program projects concerned with Alzheimer's disease and related disorders. These activities will foster heightened public awareness and provide access to accurate diagnosis and care for afflicted patients. These centers will also stimulate basic research regarding Alzheimer's disease and insure careful clinical research with new treatments as they become available. In addition, current laws and FDA regulations should be revised to provide the flexibility for quick testing and manufacture of new drugs.

RISK FACTORS

Aluminum and other Metals (Donald R. McLachlan, M.D.)

Aluminum has well documented neurotoxic properties and has been detected in regions of brain associated with neurofibrillary degeneration of the Alzheimer type. In some brain regions from patients with Alzheimer's disease the aluminum concentration approaches concentrations which are toxic to aluminum sensitive animals such as cat and rabbit. Aluminum has been detected by a quantitative trace metal analytic technique, atomic absorption spectroscopy, and by a qualitative technique employing an electroprobe microanalyser attached to an electron-microscope. This latter technique revealed aluminum to be present in the nucleus of neurons with neurofibrillary degeneration and was not noted in neurons without neurofibrillary degeneration. Despite the many similarities between an experimentally induced aluminum encephalopathy and Alzheimer's disease, it is not known whether the aluminum accumulation in Alzheimer's disease plays an active role in deranging cell functions. If it were established that aluminum was a compounding toxic factor in Alzheimer's disease, some therapeutic value might be obtained by removal of aluminum from brain perhaps by chelation. Therefore, there is need to study intracellular proteins which bind aluminum and to carry out a controlled clinical study of the effect of removal of aluminum to exclude the possibility that aluminum may accelerate the rate of deterioration in affected individuals.

Viruses (Stanley Prusiner, M.D.)

The mechanisms responsible for increased susceptibility of the elderly to viral infections are unknown. Of great interest is the Creutzfeldt-Jakob disease (CJD) which occurs primarily during the 6th and 7th decades of life. Once classified as a degenerative abiotrophy of the central nervous system (CNS), CJD is now known to be caused by an unusual slow viral-like agent. Such agents represent an especially promising avenue of investigation into the possible etiologies of senile dementia. These unusual agents cause scrapie in sheep and goats as well as kuru and Creutzfeldt-Jakob disease (CJD) in man. Collectively these diseases have been designated as the transmissible spongiform encephalopathies. After inoculation or exposure to these agents, the host remains free of disease for periods ranging from two months to two decades. The end of this prolonged incubation period is marked by the onset of neurological dysfunction. The ensuing illness is confined to the central nervous system and follows a progressive course.

Interesting parallels between the "degenerative" neurological disorders caused by these slow transmissible agents and senile dementia of the Alzheimer's type have been found. In both disorders clinical illness is confined to the central nervous system (CNS). The most prominent feature of CJD is a progressive dementia. All of the CNS diseases caused by these slow transmissible agents are characterized by the absence of fever, a lack of CSF pleocytosis as well as normal CSF glucose and immunoglobulins.

From studies on slow transmissible agents causing the spongiform encephalopathies it is now clear that these agents possess quite unusual properties and can be quite elusive. The agent is readily inactivated by treatments which denature or hydrolyze proteins. The agent appears resistant to treatments which cross-link or hydrolyze nucleic acids. To date we have been unable to demonstrate a nucleic acid component. Certainly the unusual and elusive properties of the scrapie agent suggest that if similar slow viral-like agents are involved in the pathogenesis of Alzheimer's disease these may also possess unusual and elusive properties. However, it may be more prudent to first isolate and identify the structure of the scrapie agent before continuing our search for an Alzheimer's viral-like agent.

Chromosomal Abnormalities (James Austin, M.D.)

Three years ago, our group investigated the numbers of chromosomes in normal people, in patients with sporadic Alzheimer's disease, in patients with familial Alzheimer disease, and in descendants of affected family members. Cells with 46 chromosomes are euploid. The term, "aneuploidy," is used when lymphocytes taken from peripheral blood have an abnormal number of chromosomes (were aneuploid). Lymphocyte cultures from 5 individuals with familial Alzheimer disease had a higher percent of aneuploid cells (11-16%) than did age and sex-matched normal control subjects. Increased aneuploidy was significant in each case (p.$<$.001). No particular chromosome was preferentially lost or gained. Sporadic cases of Alzheimer disease, diagnosed clinically, were also studied. Of 7 such cases, 5 showed significant aneuploidy (7-12%), but in only one case was it elevated to the degree found in the known familial cases (12%). We are aware that studies in other laboratories, using other patients, have not uniformly shown aneuploidy in familial or non-familial Alzheimer disease. Therefore, the findings of this study require confirmation. Cytogenetic changes might be related to Alzheimer's disease. Filamentous structures are involved in the neuropathology of Alzheimer's disease. Filamentous structures are also responsible for pulling chromosomes away from the equator of the cell about to divide and for distributing equal numbers of them into each of the two daughter cells. Abnormal microtubular physiology could lead to an unequal distribution of chromosomes between the daughter cells. Thus, the aneuploidy we found in lymphocytes could be compatible with other evidence suggesting a tubulofilamentous abnormality in Alzheimer's disease.

Discussion (Leonard Heston, M.D.)

I have been working at defining the contributions made by genetic factors to Alzheimer's and other dementing processes. Starting with persons (probands) with dementing illnesses proved by autopsy, I have been compiling a medical history on their relatives. With respect to dementia in otherwise normal persons which is associated with Alzheimer's neuropathological changes and which had its onset at any age, the main findings are these: (1) There is an increased risk of Alzheimer's dementia among relatives of probands with Alzheimer's dementia and the closer the genetic relationship, the greater the risk; (2) only 1/3 of families investigated had an affected relative and about 1/2 of all cases may be sporadic, not familial; (3) severity of illness within families is a most useful predictor of outcome; (4) dementia of the Alzheimer type seems to be associated with Down's syndrome, solid lymphoproliferative cancers and immune system diatheses. These associations are most apparent in severely affected families.

(Donna Cohen, Ph.D.)

I would like to present a study that was actually inspired by Dr. Heston's work. There were 7 families where Down's syndrome and Alzheimer's disease occurred within the same family. If you look at those pedigrees, you see that in a few of those pedigrees Alzheimer's disease and Down's syndrome occurred in the same generation, but in the majority of the pedigrees it occurred skipping one or two generations. One of the primary risk factors in Down's syndrome is an advanced maternal age. There are some arguments also about the effects of paternal age. We, therefore, decided to look at a group of Alzheimer patients who met research diagnostic criteria established at the University of Washington. We studied 80 patients - 50 women and 30 men, average age 70.4 years. We looked at the age of their mother and noted that about two-thirds of the mothers are over the age of 30, with a median age of 35.5 years. The median paternal age for all probands was 38.4 years. We then went to the vital statistics records, and it turns out that the maternal age or median age of controlled U.S. vital statistics data (collected since 1940) is 23.3 years. We also went to the records in Olympia and pulled out 534 controls, individuals born in 1910 in the State of Washington, looked at the age of mothers and the age of fathers and found that the median age of the mothers was 23.4, the median age of the dads 28. So what we are seeing is about a 10 year difference in the age of the mothers at the birth of a child who eventually turns out to show the clinical symptomatology of Alzheimer's disease. I think this lays open some intriguing speculative hypotheses. It suggests that we may have to begin thinking about risk factors that occur in the perinatal stage.

Genetic Studies of Sporadic and Familial Patterns of Alzheimer's Disease (Albert Heyman, M.D.)

Our present studies confirm the presence of an increase in aneuploidy and in acentric chromosomal fragments in patients with both types of the disease which had been observed previously. The precise nature of these abnormalities, their frequency in senile and pre-senile types of the illness and their presence in relatives with secondary cases of dementia or with Down's syndrome are not yet well defined and much additional work needs to be done in this area.

Chromosomes and Dementia of the Alzheimer Type (Steven Matsuyama, Ph.D.)

The search for chromosomal correlates of dementia began in the late 1960's with publications originating from our laboratory. Our first studies were done with the twins who were part of the first prospective gerontological twin study in the United States organized by Dr. Franz Kallmann and associates in the 1940's and continued to the present time by Dr. Lissy Jarvik and colleagues. Our final sample included 36 subjects. In eight there was evidence for dementia of the Alzheimer type and in these eight the frequency of hypodiploidy, was 21.6% as compared to 12.9% for those of a similar age without dementia, a statistically significant difference ($p < 0.0001$). Among the men, no significant difference in aneuploidy emerged. The sex difference is as yet unexplained.

The chromosomal changes reported suggest that further cytogenetic studies are warranted. At the moment, however, caution is advised in attempting to use chromosomal findings in making individual predictions of who is (or who is not) at increased risk of developing dementia of the Alzheimer type. The available data do not support using aneuploidy frequency or any other data as a predictor of disease. To shed some light on the factors important to the development of this devastating disorder future investigations should include interdisciplinary prospective studies of individuals with dementia of the Alzheimer type and their families.

STRUCTURAL CHANGES IN THE BRAIN

Changes in Dementia (Robert Terry, M.D.)

In the final analysis, the diagnosis of Alzheimer's disease in either the presenium or the senium can be made only in the presence of particular structural changes. Loss of cortical neurons has been demonstrated as part of the normal age process. The rate is not consistent throughout the central nervous system, with several functional groups in the brain stem apparently maintaining normal populations throughout life. Our own series compared twelve normal specimens aged between 70 and 89 years and 18 specimens of SDAT of the same age group. The counts demonstrated that in SDAT there was a major loss of large neurons beyond that of normal aging. In the mid-frontal and superior temporal regions, this decrement amounted to 40 to 46% of the neurons measuring over 90 microns square in cross sectional area.

Smaller neurons were less affected, and glial numbers were not much changed. Immunocytochemical assays, however, showed that the number of fibrous astrocytes increased approximately fourfold in SDAT. A progressive loss of dendrites, especially those coming from the base of cortical pyramidal cells, has been well described in normal aging. This process, however, is much exaggerated in the presence of SDAT. Furthermore, the number of synaptic spines per unit length of dendrite also falls in normal aging, and declines yet further in the diseased state. Alzheimer's neurofibrillary tangles and neuritic plaques are the histologic hallmarks of SDAT, and their concentration in the cortex correlates strongly with the degree of dementia. The tangle is a mass of argentophilic fibers in the cytoplasm of neurons, and is made up at the ultrastructural level of great numbers of paired helical filaments. Each individual filament within the pair is 10 nm.thick and is apparently free of side arms. The two fibers cross over each other at intervals of about 80 nm. Recent immunocytochemical studies indicate that the paired helical filaments are related to a protein which is present in normal brain tissue. Neuritic or senile plaques have a central core of amyloid, surrounded by enlarged abnormal neurites which are predominantly presynaptic boutons. These latter are filled with paired helical filaments, lamellar lysosomes, and degenerating mitochondria, accounting for the increased hydrolytic and oxidative activity demonstrable in the plaque. The nature of the amyloid is not yet clear, some evidence pointing toward its being made up of globulin fragments, other data pointing toward a variety of APUDamyloid. It is perhaps surprising that none of the structural changes characteristic of SDAT are unique. All are to be found to a greater or lesser extent in normal elderly. Their casual relationship to the disorder must be viewed as a threshold phenomenon.

Abnormal Proteins (Michael Shelanski, M.D.)

In 1906, Alzheimer recognized an increase in size and apparent thickening of the neurofibrils in the neurons of patients succumbing to presenile dementia. Similar changes were also to be found in the majority of cases of senile dementia. However, electronmicroscopic studies reported independently by Terry and Kidd in 1963 showed that the fibrils in Alzheimer's disease are unique in their appearance. They are composed of a pair of filaments wound helically one around the other with a period of 160 nm. These paired helical filaments (PHF) are unique to the neuron and to certain human diseases.

Neurofibrils are recognized to be normal constituents of nerve cell bodies and their axons. Electron microscopy revealed that there were three distinct types of fibrous structures in the neuron-microtubules, neurofilaments and microfilaments. The microtubules are unbranched, tubular structures of great length. The tubule itself is composed of a protein called tubulin which has a molecular weight of 110,000. Neurofilaments are composed of a "triplet" of proteins with molecular weights of 68,000, 150,000 and 210,000 daltons respectively. Recent evidence indicates that neurofilaments and microtubules are transported at the same rate in the axon and that they are capable of interactions with each other. These fibrous organelles serve as an organizational framework performing skeletal and motile functions in the neuron and playing critical roles in the establishment of cellular form, the economy of the cell, in axonal transport and in neurotransmitter uptake and release. Recent analysis has indicated that the antigen in the microtubule fractions which reacts with the PHF is neither tubulin nor neurofilament triplet proteins. However, it is present in both normal human and normal calf brain. Thus, if the PHF is composed in major part or totally of this material, it is derived from normal brain constituents and is not the product of a mutant or viral gene. Firm conclusions await isolation and purification of the PHF.

SOCIAL AND PSYCHOLOGICAL ASPECTS

Psychological Diagnosis and Treatment (Donna Cohen, Ph.D.)

With all the psychological treatments we do, the psychotherapies, the behavioral management strategies, the group work, the cognitive enhancement strategies, none of them work, unless you support the family. As one of our patients said, "When I go, my wife goes." Clinical services that are very important to the families are really adequate diagnostic and evaluation services. Direct medical care for the acute symptoms - the depression, the paranoia which often exist in these patients, care of other concomitant physical illnesses, doing a medication check, sometimes withdrawing the patients from medication and restabilizing them, information, advice to the families, saying to the son, the daughter, there is no evidence there is any Alzheimer's or dementing illness in your family. Long-term planning is probably one of the most important things we can do: Sit down with the families to map out the crisis they suffered, to help them plan coping strategies to deal with these and other kinds of problems and to begin to look towards the future where institutionalization, bereavement and other issues become more important. Psychotherapy, supportive psychotherapy, and group therapy are very effective. I think our family support groups are adequate if not superb preparation for continuing counseling and/or therapy with friends and/or more advanced significant others. Crisis intervention occurs, group formation is enormously valuable, home visits - many of our families are trained lay therapists by the time they have gone through many months of small groups. Change in the environment is probably one of the most important things we can do also.

Families have problems just as the patients do. They have psychiatric problems, they have health problems, they have adjustment problems. I don't want you to think there is a right way or a wrong way to adapt to dementia. I think you use the professionals that are available to you and you use the most upbeat and updated information available. The psychologist, I think, becomes a valuable colleague with the other health professionals and I just want you to know that data are there and someday, I hope, the knowledge about the brain will come a little bit closer to the human beings that we are all trying to treat.

Impact on Family: A Personal Viewpoint (Ms. Bobbie Glaze)

I would like to share with you the concerns of the family struggling with Alzheimer's disease. I can tell you that it is like a funeral that never ends. My husband was a handsome, vital, athletic man, a civic leader, a public speaker, a highly respected business man. He is now a statistic. He is permanently hospitalized, not knowing his family or speaking a word in the past four years. He requires total physical care. I have a husband, but I speak of him in the past tense. I am not a divorcee; I am not a widow; but where do I fit?

I began noticing eccentricities, withdrawal from society, disinterest, lack of communication about 12 years ago. In 1970, he was forced to retire. I excused, guided, and denied that this was happening. I found part-time employment, but each day it was more difficult to be away from him. We dipped into our savings, were managing on very little income, losing everything we had. I finally admitted we needed help. We had no neurologists in our area of South Dakota, so a daughter persuaded us to come to Minneapolis where she could lend a hand. I decided to uproot (my husband could no longer make decisions). I was given the diagnosis in a hospital waiting room filled with people. The doctor said, "Your husband has Alzheimer's disease, a progressive, irreversible, brain deterioration, for which there is no known cause nor treatment. That's the way it is. You'll have to go on from there." He excused himself and left to see another patient. I have never seen that doctor again. I was in a strange city, and I was not free to find employment. I tried work situations that might provide rent-free housing, but even that was impossible. We moved 5 times in 18 months, by necessity. We lived in an ever-diminishing world. His company of 25 years chose to terminate all his benefits (disability, pension, insurance) because of this "early retirement." I was unaware of V.A. assistance. I had accumulated living expenses, hospital costs, relocating costs, legal expenses, until we had no reserve.
With the 24 hour vigil, I became totally exhausted -- physically and emotionally. It became frightening, living with this stranger who might push me or twist my arm, or throw things at the television. The loving, gentle husband I once knew was no longer. Eventually I placed my husband in a nursing home.

My husband stayed in a nursing home nearly 3 months, when I received a call that he had become violent and they refused to keep him, even overnight. They did not know how to care for this kind of patient. They sent him to a private hospital, from which he was admitted to a V.A. hospital. Fortunately, he remains there. But many of our veterans, even career service men are being turned away because they are suffering from an "untreatable" disease.

After my husband's admission to the V.A. I came home to my very small apartment feeling a despair that is impossible to put into words. I was suddenly alone. As for myself, I was becoming a non-person and realized that my thinking must be turned around. My children were caring and supporting, again a blessing, for not all families find this to be true. Acceptance is probably the most difficult step for our families, and there are thousands of us. For a long time we look for improvement and for things to get better. This is not true with Alzheimer's disease. The condition only worsens.

We need assistance with the appropriate type of care as the disease progresses, whether it is day care, respite care, home care or long term care. One cannot survive very long when dealing with this around the clock. We must find ways to provide care facilities for our people who have no place to go. We need direction in business matters, for we must plan ahead toward when the afflicted individual is declared incompetent. The very real tragedy is for the younger family who is faced with the disease that will continue on for a period of many years. There are often young children who will need to be educated and cared for. There are many variables in patients and therefore the duration of the illness varies also. Physical deterioration is usually a determining factor. In our family it has been at least 12 years. We had been advised to divorce, and some have. Some lose their homes, and most material things as I have. We have already lost a loved one in this slow devastating process that diminishes one to a shell that simply breathes. We can do nothing for that victim at this time. Research is the hope for the future. We can help ourselves and do much to help others. This is the reason for my involvement today.

In our National Association for Alzheimer's Disease and Related Disorders, I am privileged to serve on the Board of Directors and also serve as National Chairman for Program Development. Since December of 1979, we have established major groups in 15 states with 4 others awaiting acceptance and many others in the development process.

Impact on Family (Monica Blumenthal, M.D.,Ph.D./Robert Marin, M.D.)

Relatively little research has been done to explore the nature of the burden which a deteriorating older person places on his caretakers, although workers in the field agree that the burden may be extensive and the problems created for the caretakers severe. We have found it useful to conceptualize burden as resulting from the interaction of a variety of factors. The first is the set which represents the characteristics of the patient brought on by the illness. This list includes such traits as wandering, dangerousness (generally to self rather than others), falls, immobility and other conditions which place a burden of lifting and carrying on the family members. Secondly, traits that interfere with the caretaker's sleep are particularly troublesome. Better tolerated by most families are inabilities in activities of daily living that necessitate assistance with dressing, bathing, shopping, managing money, and preparing meals. Patient characteristics contributing to family burden can be described in terms of the degree of vigilance required, that is, the extent to which there is a need for moment to moment attention. The degree of physical labor is also important. The immobile patient or the heavy patient who falls repeatedly would produce more difficulty than the mobile patient who is able to manage for himself physically. Also, the characteristics of the environment can act to make the burden easier or heavier - e.g., the presence or absence of stairs, elevators, handy bathrooms.

The presence of a helpful social support system may contribute in major ways to making the burden bearable. At some point it may become almost impossible for the patient to remain at home. This may be the case if patients wander, are a danger to themselves or others, are incontinent, or interfere with their caretaker's sleep. In any case, it is important to remember that family burden is a complex issue requiring additional research.

Discussion (Agnes Buchanan, R.N.)

The cerebral atrophy and the attendant physical deterioration which occur in dementia can be rapid, or slow. The fact remains that in the end we have a pathetic creature, living, but not alive, who may be childlike, violent, animalistic, depressed, often incontinent. What are we doing for these once alive human beings who cannot speak for themselves?

What do I tell the client who comes to me with neurological changes - sometimes minimal, but they are there. These people are alert enough to be aware that something is happening to them. They are depressed, of course, but they are TERRIFIED. "What will happen to me? Will I become a vegetable, drooling, dribbling, incontinent, withdrawn, hostile, combative, curled up like a baby? OH! GOD HELP ME. How will I pay? Johnnie and Sue each have their own lives -- they've got kids -- where will I go -- who will care for me? Who will pay for me?"

Insurance, except for Medicaid, available to welfare recipients, does not reimburse for such illness. Yet, third party reimbursement is available for diseases which in fact are self induced by our life style, e.g. alcoholism, Chronic Obstructive Lung Disease, Lung Cancer, Ulcers, to name a few. AND THERE IS NO EXCUSE.

How can we get quality care with as little financial and emotional burden as possible? That is our dilemma. Some things to be done while we are waiting for the results of the research are: recognition that dementing illness is a result of degenerative brain disease; awareness of the extent of dementing illness in our society and recognition that as the aging population grows so will the number of persons with dementia; education; and development of better medical insurance coverage to deal with this catastrophic problem. In addition, moves must be made toward encouraging in-home care by providing outside support systems to encourage families to maintain loved ones at home. Those systems would include: home health care, including education and training for family members in the care of the patient, day care, in-home respite care; and in-home pastoral care when appropriate.

It is our duty to speak for these folk -- they cannot speak for themselves -- Soon the hat may be on the other head, yours and mine, and we may need someone to carry on for us.

Summary-Recommendations to White House Conference (David Drachman, M.D.)

A number of weeks ago Dr. Katzman asked me to summarize what had gone before over the course of a day and a half - everything about Alzheimer's and Related Diseases - and make some recommendations to be passed on to the White House Conference on Aging.

It is rather obvious that despite the fact it is now 75 years since Alois Alzheimer first named this disease, we have really not proceeded as well as we might to determine the etiology, the inheritance, the clinical course even. We don't have a simple laboratory diagnostic test. We don't know how to treat it. We have only begun to struggle with some of the social implications. Is that hopeless? Not at all. We have many important clues now. We have testable hypotheses. We have people willing to go after them. That is [illegible] key to this while thing.

The talks essentially covered clinical areas, mechanisms of causation of Alzheimer's disease and other related dementing disorders, and ways in which we can care for patients who have Alzheimer's disease. I would like to follow that pattern in my summary.

First, we did not argue about the definition. That itself is quite remarkable, I think. Everybody agreed that dementia was deterioration of mental function from a previous level. No one insisted on some of the semantic quirks that made this a tedious and difficult problem as recently as 1977 at the symposium at the National Institute of Health. Now we agree on that point.

Looking at the epidemiology of this condition two facts stand out from Dr. Schoenberg's presentation. One is a marked age relationship. Nothing subtle. Over the age of 80 one has a 400 fold chance of getting Alzheimer's disease in any particular year as compared with a person who is between 30 and 60. That is a critical point to be mentioned. Furthermore, women seem to be more susceptible to this disorder than men.

What about the etiology of this disorder on a clinical level. As Dr. Katzman pointed out, there are more than 50 etiologies that we have recognized and undoubtedly a few that we have not as yet recognized. But just to remind you Alzheimer's disease accounts for roughly 50% of all the dementia that occurs. Dr. Katzman discussed multi-infarct dementia which accounts for at least 20% of all demented individuals; the combination of multi-infarct and Alzheimer's account for 12 to 15% in addition. Thus the remaining 15 to 20% of all cases of dementia are related to the other 50 kinds of disorders and many are treatable and reversible. Dr. Katzman pointed out that multi-infarct dementia may have a number of treatments that are really quite practical, some of them preventive.

Dr. McHugh picked up on the problem of depression which may masquerade or manifest itself as dementia. As far as depression is concerned the critical diagnostic points were not so much psychological tests, but rather a history of previous episodes of depression or family history of a manic depressive type of disorder. I think we have some ideas how to treat depression, at least individual attacks, and Dr. McHugh described the successful use of drugs and electroshock therapy.

One of the most outstanding hypotheses regarding dementia in Alzheimer's is the cholinergic hypothesis that John Growden alluded to and Peter Davies also commented on. Aside from the pathology and clinical course this has been the most consistent and the most dramatic of all the observations we have made. The decline of choline acetyltransferase and the production of dementia in young people with cholinergic blockers have stood up time and again. Dr. Blass pointed out that a loss of cholinergic activity may occur not only with a primary disorder of cholinergic synthesis, but also in relationship to a decline in energy metabolism.

He pointed out that the brain doesn't have to undergo a power failure; it is not as if all the lights go out. The very first thing that happens as energy metabolism declines is that neurotransmitter systems begin to fail and this is a realistic, possible mechanism where one could link decreased cerebral metabolic rate of oxygen, decreased utilization of glucose or decreased blood flow to the decline in activity of the cholinergic system.

Treatment so far has been largely oriented to improving or rather increasing cholinergic function by the use of physostigmine experimentally, lecithin and choline. It appears that a few patients have improved to a modest degree. But this is certainly not the cure-all that we all would like to find. It is important, as Dr. Growden pointed out, that we have drugs that are both post-and presynaptic facilitators of the cholinergic system so that we can work and play with this system at one end and the other and perhaps end up with something effective. An analogy might be the treatment of leukemia, where most of the drugs that have now produced cures in a large proportion of cases were available ten years prior to the time at which cures actually took place, but not used in the right combination. So, while it is not necessary that we have a drug that is as good as penicillin for pneumonia, it may be that some other combination of drugs will work.

Dr. Benson talked about PET-scanning. This is really a new area entirely. The PET scanner is not a practical diagnostic tool. I don't think NIH would support one in every community hospital, but it does give us a new handle on this problem. Since we don't have an animal model of dementia we really have to look at people. We want to be able to observe their metabolic rates. We want to be able to use appropriate probes without danger and without harm to those individuals. The PET-scanner gives us not only that capability but an objective measure of how their brains are functioning. We try to worry about two things: (1) what are their cognitive processes like - what is their behavior, what are they actually doing; and the other one is (2) how is the machinery. Is the machinery intact. Is it capable of functioning properly, if only it had the right information in it. So, I think the PET-scanner gives us the capability of looking objectively at the state of function of the machinery and it is rather different from psychometric testing in that regard.

Dr. McLachlan brought up the question of aluminum and other toxic metals that may be related to dementia. He put it in a reasonable way; he pointed out that it is not the Wearever pans that we all probably have at home, it is not the antiperspirant that we may be using which contains a lot of aluminum that are liable to give us dementia, but that some people handle aluminum rather worse than other people; that is, there may be a primary defect, perhaps induced genetically, perhaps induced by viral agents or whatever, that results in an accumulation of aluminum in the nuclei of nerve cells in Alzheimer's Disease.

Dr. Prusiner discussed viral etiology; and although he was not specifically alluding to Alzheimer's Disease as being a viral disorder, he drew parallels with Jakob-Creutzfeld disease, Kuru, Scrapie, and the other transmissible types of dementing disorders. A number of other people have also pointed out that there are ubiquitous latent viruses that may be doing a nasty job on the brain as well. What form they take when they happen to modify their antigenicity and insert themselves into the genome we don't know.

Dr. Austin discussed chromosomal changes, particularly in familial Alzheimer's disease. He took a very interesting and conservative point of view, having pointed out to us that there are cases of aneuploidy in most of his series of familial Alzheimer's disease and in a large proportion of the non-familial Alzheimer's. The explanation of this is worth considering carefully - It is not quite clear whether this aneuploidy or alteration of chromatin is necessarily a genetic cause of Alzheimer's disease or whether this family's peripheral blood reflected a change in microtubules in lymphocytes just as it might happen in the brain, perhaps producing neuro-fibrillary tangles or other alterations. The discussants pointed out there were familial cases of Alzheimer's disease and that Down's syndrome tends to occur together with Alzheimer's disease in some families. Dr. Cohen pointed out that it may be the age of the parents rather than the association with Down's syndrome per se that produces both Down's syndrome and Alzheimer's disease. If you had old parents you may be more susceptible to developing Alzheimer's disease late in life.

Dr. Terry discussed the anatomy and pathology and I think it is of critical importance that at last his exquisite techniques have been able to demonstrate what has been suspected for a long time, namely that in Alzheimer's disease itself there is an excess loss of a particular class of neurons over and above what happens with normal aging. I think it is very important to know that the larger nerve cells, those with areas over 90 square microns, are decreased in Alzheimer's disease compared with age-matched controls. He also described some of the other phenomena that include paired helical filaments that present in nerve cells with neurofibrillary tangles and senile plagues which involve the connections among nerve cells. It is worth stressing that all of these phenomena are seen in normal aging and the changes in Alzheimer's disease may be quantitative phenomena. There seems to be a threshold; you see a little of it in everybody but it is a disease when it occurs in a very large amount. Editorially, I will simply point out that it is certainly possible that age and a variety of other factors may interact with Alzheimer's disease or other types of pathogenic mechanisms. It may very well be that there is a neural reserve that we all have, I am sure that we are all born with it - we can spare a few cells we can spare a few connections. Below this threshold, dementia probably occurs.

I think the critical question arises at this point, is Alzheimer's disease a final common pathway for all of these changes? It is possible that all of the slings and arrows of time and age, viruses, alterations of proteins, anoxia, ischemia etc., may end up with some final common pathway that looks rather like this and is it possible, for example, that its pathology and pharmacology have rather stereotyped characteristics. We do not know this at this point.

Dr. Shelanski talked about tubules and filaments. I think it is 15 years people have been analyzing the filaments and tubules that may correspond to paired helical filaments seen electron micrographically in Alzheimer's disease and are still not entirely sure exactly which protein has gone awry. It is not normal neurotubule protein and not normal neurofilament protein that are responsible for the paired helical filaments. This is undoubtedly an important area for future research.

Dr. Cohen spoke about the psychological aspects of management of patients who have Alzheimer's disease, getting to the very practical aspects. She has outlined for us the need for careful psychometric evaluation, the importance of centers providing comprehensive evaluation and follow-up, the need for community support systems and facilities. There is nothing I can say about what Bobbie Glaze had to tell us. It is better than a picture and it is certainly worth more than a thousand words to hear her, an articulate individual, describe an experience. In a way it sounds a lot like a war experience, hard to believe, but vivid in the mind of the person who has experienced it; critical for us to recognize the impact of it and avoid future repetition.

Finally, Dr. Marin told us something about the impact of Alzheimer's disease on the family. Personally, I have been very impressed with his four-point nursing home criteria: If patients wander, if they endanger themselves or others, if they are incontinent or spoil others' sleep, it is very hard to keep them at home, and placement is probably indicated. But this, of course, has to do with the frailty or resistance of the individual who is on the receiving end, giving care.

Obviously, on the basis of these talks and other thoughts, there are a number of points that we should stress.

The magnitude of the problem cannot be overstressed. The fact is that 15% of the population over the age of 65 is likely to develop dementia. The way I like to describe this is in talking to a group of relatively young people, is that one out of 3 of us whose parents survive past the age of 65 will be involved in their care because they will be disabled by dementia. (That is, 1/6 of the population are afflicted and there are 2 parents per individual).

The expenditures seem dreadfully disproportionate. It has been pointed out that just the nursing home costs are over 10 billion dollars per year and the research funds available are approximately one-thousandth of that, or 10 million dollars per year. I think this point has to be driven home in the most forceful manner possible.

The need to reorder priorities is obvious. How can we spend a thousand dollars on maintenance for every dollar that we spend in an effort to prevent, treat or cure dementing disorder? It seems unrealistic to me, and, I think, to all of us.

Based on these discussions, we can come up with recommendations for a four-part program to deal with the dementing disorders. The first has to do with supporting basic and clinical research. The second has to do with realistic clinical management and state of the art diagnostic and treatment centers. The third has to do with a responsive social support system. The fourth is regarding the educational system.

1. We need both research support and efforts to attract additional investigators. There are not enough of us who are interested in doing research in the field of aging. As far as basic research is concerned, it is wide open, from the precise etiology to a more general type of description of exactly what the natural history of Alzheimer's disease is. We do not know enough about pharmacology, genetics, virology, toxins, biochemical disorders, vascular disease, immunology - all of these being possible modes of etiology, one or more than one simultaneously, in producing Alzheimer's disease. We need to know more about the pathology and particularly the pathophysiology and their consequences. We need animal models of dementia. Clinically, I think we know too little about the course and range of phenomenology in the dementing disorders. CT evoked potentials and PET scan changes need further evaluation. We need objective measures of brain functioning. Much more needs to be done.

2. We need a series of specialized centers for realistic clinical management. We need places where state-of-the-art diagnosis, entry into the system, genetic counseling, and treatment can take place. How do all those patients out there hear the message? They may

tune in their radios, they may get our literature and they may not. They need a place to go. A good clinical center which feeds patients into the treatment and support system is an ideal facility.

3. *Development of a responsive social support system is critical*. For those not able to cope with a normal life but not totally incapacitated or oblivious to their surroundings, we need more of what we have all heard about - day care centers, meals-on-wheels, family support, and a whole network of health and care systems. And for those who can no longer make it, we need good nursing facilities, where the nurses and the doctors know what they are doing and how to deal with these patients.

4. *Education is critical*. It is important for physicians, families, allied health professionals, and for the general public as well.

Overall, our priorities are as follows: prevention, cure, treatment, assistance and care. This is exactly the reverse of the way in which these things are being funded at this moment. I think we need to redress that and turn it around. *Prevention should be number one*. Care should be last, because by investing in prevention we will ultimately be able to reduce the number of individuals who are afflicted.

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the 1981
White House
Conference
on
Aging

Report of the Mini-Conference on Veterans

MCR-28

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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INTRODUCTION

There are over thirty million veterans in the United States today, and additional millions of their spouses, survivors and dependents as well. Taken together, veterans and their families comprise some forty-four percent of the total population of the Nation.

The average age of these thirty million plus veterans is 48 in 1981. There are over twelve million veterans of World War II who now average sixty years of age, and an additional 5.8 million veterans of the Korean Conflict with an average age of 51. Over one-half million veterans of World War I are still living, at an average age of 86, and, there are even about a hundred veterans of the Spanish American War alive today.

Within the context of aging, then, the veterans' population comprises a major segment of those Americans in their sixties, seventies, eighties and nineties. In fact, by the 1990's, over one-half of all males over age 65 will be veterans.

These statistics point to a dramatic increase in the volume of demand for services and benefits from the Veterans Administration and other programs for older Americans, as veterans from World War II, and right behind them Korean Conflict veterans, enter into their senior years. In light of this anticipated "tidal wave" of aging veterans and their widow(er)s, the veterans service organizations implemented a mini-conference, recognized by the White House Conference on Aging, to examine the issues and make recommendations to address the aging veterans population and its upcoming dramatic increase in size. The VETERANS' CONFERENCE ON AGING was convened in January and February 1981 by the veterans' community, and this Chapter represents its report to the Delegates and Observers of the 1981 WHCOA National Meeting.

A FORUM FOR CONSENSUS

The Veterans' Conference on Aging was convened by the American Legion, AMVETS, Disabled American Veterans, Veterans of Foreign Wars of the U.S., and Veterans of World War I of the U.S.A., with Veterans of World War I National Commander William G. (Bill) Fisher serving as Conference Chairman. An executive committee of representatives of these organizations, the Veterans Administration, and the White House Veterans Coordinating Committee provided a decision-making group to design and manage the Conference.

The goal of the Conference was to provide a fair and open forum through which veterans and military organizations could reach a consensus on those issues, concerns and recommendations which could have an impact on the aging veteran population.

The Conference was divided into three sections to accomplish this. First, a Federal Briefing on Veterans' Aging was convened at the American Legion headquarters in Washington, D.C., in January 1981. At this event, veterans and military groups heard from Federal agencies and Congressional committees about what benefits, services and legislation were on the books or being contemplated, and about the perspectives of respective speakers on the issue of veterans' aging. Participating in this briefing were the White House's Conference on Aging and Veterans Coordinating Committee; the Veterans Administration; the Departments of Defense, Labor, Health and Human Services, and Housing and Urban Development; and the Social Security Administration and the Office of Personnel Management. From the Congress, the Senate's Committees on Veterans Affairs and on Labor and Human Resources, and the House of Representative's Committee on Veterans Affairs and Select Committee on Aging, each had staff representatives address the event as well. Over seventy persons participated in this Federal Briefing.

The second event of the Conference was the Veterans' Symposium on Aging, conducted at the Veterans of Foreign Wars Building in February 1981 in Washington, D.C. At this event, delegates of veterans service and military organizations and associations met to respond to the information provided by the previous Federal Briefing, and to the interests of their own respective organizations, by promulgating and passing resolutions. In addition, the delegates heard from Congresswoman Margaret M. Heckler, the keynote speaker, about aging, veterans and geriatrics issues. Some sixty persons participated in this event.

Finally, a Conference Reception was held at the conclusion of the Symposium at the Disabled American Veterans Building in Washington. Some 140 veterans, aging, Federal and congressional representatives joined together in an informal atmosphere to recognize Congressman Claude D. Pepper, a World War I veteran who is Chairman of the House Select Committee on Aging.

The following veterans service organizations and military organizations participated in the Veterans' Conference on Aging:

Air Force Association
Air Force Sergeants Association
American Gold Star Mothers
American Legion
American Red Cross
American Veterans Committee
American Veterans of World War II, Korea and Vietnam (AMVETS)
Blinded Veterans Association
Catholic War Veterans of the U.S.A.
Disabled American Veterans
Gold Star Wives of America
Jewish War Veterans of the U.S.A.
Marine Corps League
Military Order of the Purple Heart of the U.S.A.
National Association for Uniformed Services
National Association of Military Widows
National Association of State Directors of Veterans Affairs
National Association of State Veterans Homes
National Black Veterans Organization
National Veterans Law Center
Non Commissioned Officers Association of the U.S.A.
Paralyzed Veterans of America
Stars and Stripes/National Tribune
Retired Officers Association
United Spanish War Veterans
Veterans of Foreign Wars of the U.S.
Veterans of World War I of the U.S.A.

This totals to twenty-seven organizations and associations which joined together in a deliberation of the aging veteran issue. Working together, through a Briefing, a Symposium, and then relaxing at a Reception, these organizations and the other Federal and Congressional participants were able to conduct the first major, national event addressing veterans' aging in the future.

CONFERENCE RECOMMENDATIONS

The January 1981 Federal Briefing on Veterans' Aging served as a "baseline" of information and comment on the aging veteran population, its projected growth, and the problems veterans will be confronted with in the 1980's and 1990's. The Veterans' Symposium on Aging provided for a forum where each participating organization could provide up to two (2) voting delegates to submit, discuss, and vote on Resolutions of the Conference. Thus, the recommendations of this Conference represent the consensus of the delegates (by majority votes), and not necessarily the official positions of their respective organizations. Also, these Resolutions were passed with not only the White House Conference on Aging in mind, but also addressing the Congress and the Federal establishment, through a public version of this report distributed in March 1981.

- Resolution Number 1

TO PRIORITIZE PROGRAMS AND LEGISLATION FOR AGING VETERANS

WHEREAS, there are over one-half million living American veterans of World War I with an average age of 86; and whereas, there are over twelve million American veterans of World War II who are now entering their sixties and seventies; and whereas, there are nearly six million veterans of the Korean Conflict approaching older age; and whereas, there are additional millions of spouses and widow(er)s of veterans in or nearing older age; and whereas, these millions of veterans and their spouses and widow(er)s will constitute a major increase in demand for services and benefits to meet their needs as senior citizens; now, therefore:

BE IT RESOLVED, by the 1981 Veterans' Conference on Aging, that programs and legislation affecting aging veterans and their spouses and widow(er)s receive priority treatment by veterans, Federal, aging, and private-sector organizations, and by committees of the Congress; and

BE IT FURTHER RESOLVED, that the White House Conference on Aging assign greater priority to veterans as a major segment of the aging population of the Nation.

- Resolution Number 2

TO INCREASE VETERANS SERVICE ORGANIZATIONS' PARTICIPATION IN AGING AFFAIRS

WHEREAS, veterans service organizations represent the interests and concerns of an estimated ten million veterans, and their auxiliaries; and whereas, these organizations provide expert liaison and communications with the Congress, Federal entities, and other organizations, associations and entities, on behalf of veterans; and whereas, there is a multitude of organizations, entities and Congressional committees with mutual interests in meeting the needs of veterans and aging citizens; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that veterans service organziations enhance their liaison with the Congress to include the Senate Subcommittee on Aging and the House Select Committee on Aging, in concert with aging and other organizations and associations; and

BE IT FURTHER RESOLVED, that veterans service organizations are encouraged to enhance their communications and coordination with those other organizations, associations, and entities committed to serving the aging population of the Nation.

- Resolution Number 3

TO APPLY RESOURCES OF VETERANS SERVICE ORGANIZATIONS TO COMMUNITY PROGRAMS FOR AGING AMERICANS

WHEREAS, veterans service organizations maintain state and local entities, often with physical facilities, in thousands of American cities and towns; and whereas, these local entities have historically provided voluntary services and community programs on behalf of veterans and their families, and the public-at-large; and whereas, in many instances local entities of veterans service organizations have initiated day care and other programs specifically for aging veterans, their spouses, and widow(er)s; and whereas, the demand for community-based programs to meet the needs of aging Americans, such as day care, nutrition, transportation, education, comraderie, will dramatically increase in the 1980's; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that veterans service organizations seek to enhance their community programs and voluntary services to assist aging veterans and their beneficiaries; and

BE IT FURTHER RESOLVED, that the Veterans Administration be encouraged to provide training, technical assistance, and support to local entities of veterans service organizations in the development of programs to assist the aging.

- Resolution Number 4

TO ENHANCE OUTREACH AND PUBLIC INFORMATION FOR AGING VETERANS

WHEREAS, limited outreach and public information efforts exist at the national level to advise older veterans of the available programs and benefits which can assist them; and whereas, as a consequence numerous veterans and their spouses and widow(er)s are unaware of such assistance and therefore have not filed for it; and whereas, such programs and benefits can accommodate or contribute to health, housing, employment, transportation, nutrition, and other living necessities; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that the White House Conference on Aging and veterans service organizations seek enactment of legislation to provide for an extensive outreach and public information program to inform aging beneficiaries of all programs and benefits available to them, including eligibility requirements; and

BE IT FURTHER RESOLVED, that the Veterans Administration enhance its efforts to inform aging veterans of their entitlements and VA services through increased outreach programs.

- Resolution Number 5

TO PROVIDE FOR A PENSION FOR WORLD WAR I VETERANS

WHEREAS, there are over one-half million living veterans of the 4.7 million who served their country during World War I, who are now an average 86 years of age; and whereas, these veterans served their Nation in wartime, valiantly and honorably; and whereas, these veterans have not received a separate pension program to assist them in their senior years, while, at the same time, they were instrumental over the years in helping to create a modern program of benefits and services which veterans of more recent wars have benefited from; and whereas, by virtue of their age these veterans are no longer employable, yet at the same time, they all too often subsist at or below poverty levels; and whereas, these veterans are increasingly found in nursing, geriatric, and long-term medical care institutions, both public and private, while often having no means to provide for such institutionalization or for their widow(er)s; and whereas, time does not eradicate this Nation's obligation to its veterans for their service in the Armed Forces on its behalf; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that the White House Conference on Aging and veterans service organizations seek to enact legislation to provide for an equitable pension program for the remaining veterans of World War I and their widow(er)s.

- Resolution Number 6

TO REVIEW AND RECONSIDER PROVISIONS OF THE VETERANS' AND SURVIVORS' PENSION IMPROVEMENT ACT OF 1978

WHEREAS, the Veterans' and Survivors' Pension Improvement Act of 1978 (Public Law 95-588) was developed to provide veterans and their survivors with a more equitable benefit program; and whereas, there are provisions of this Act which identify unfair inclusions and exclusions which have detrimental impacts on determinations of entitlements; and whereas, there are other aspects of this legislation which contradict its intent of improving pension benefits for veterans and their survivors; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that veterans service organizations seek amendments to this legislation by the Congress which will reduce the detrimental impacts of its provisions on veterans and their survivors.

• Resolution Number 7

TO INFORM AGING VETERANS OF DISCHARGE UPGRADE PROCEDURES

WHEREAS, standards of military discharge during and after World War II were stricter than today's standards, and procedural rights were severely limited as compared to those of today; and whereas, less than honorable discharges can prevent aging veterans from receiving services and benefits which can assist them; and whereas, their spouses and widow(er)s may seek benefits only to discover that they are not eligible due to a less than honorable discharge; and whereas, veterans service organizations worked to establish the Discharge Review Boards and the Boards of Correction of Military Records as a means for veterans to appeal less than honorable discharges; and whereas, by today's standards, veterans receive a high rate of success in upgrading their discharges and therefore becoming eligible for veterans benefits; and whereas, many aging veterans are not aware of procedures to upgrade their discharges; now, therefore:

BE IT RESOLVED, by the 1981 Veterans' Conference on Aging, that the White House Conference on Aging assist in an effort to inform aging veterans of discharge upgrade procedures through outreach among various organizations, associations and senior citizens networks.

• Resolution Number 8

TO AMEND LEGISLATION WHICH EXCLUDES CERTAIN MILITARY SERVICE IN THE CALCULATION OF RETIREMENT ANNUITIES OF FEDERAL CIVIL SERVICE RETIREES AFTER AGE SIXTY-TWO

WHEREAS, the enactment of Public Law 84-881 requires that at age 62 and thereafter all federal civil service retirees who are veterans and who have combined their military service and federal civil service for calculation of their civil service annuity when eligible for Social Security benefits due in any part to military service must exempt a recomputation of their annuities, omitting all credit for military service after 1956; and whereas, the provisions of this legislation were enacted into law without adequate hearings or evaluation of the long-term impact; and whereas, all veterans should be entitled to the maximum benefits payable commensurate to earnings paid into the Social Security system; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that Public Law 84-881 should be amended by the Congress to eliminate those provisions which reduce maximum entitlements for veterans who later serve in and retire from the Federal civil service.

- Resolution Number 9

TO PROVIDE FOR A COMPREHENSIVE VETERANS ADMINISTRATION PROGRAM OF HEALTH CARE AND OTHER SERVICES FOR AGING VETERANS

WHEREAS, the population of veterans who are age 60 and over will dramatically increase during the 1980's; and whereas, the population of these veterans who reach age 65 and over will triple by the late 1990's; and whereas, the health care and other service needs of the total veterans population of over 30 million will be significantly influenced by the particular health care and other needs of these aging veterans; and whereas, the Veterans Administration will be required to revise its current configuration of health care and other services to meet the demands imposed by this growing population of aging veterans; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that the Veterans Administration provide for a comprehensive program to meet the health care needs and other service needs of the aging veterans population; and

BE IT FURTHER RESOLVED, that the plans of the Veterans Administration to meet the needs of the aging veterans population be submitted to the Congress for review and public hearings at which veterans service organizations may be provided input into a final comprehensive plan.

- Resolution Number 10

TO ENHANCE AND EXPAND THE GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTERS PROGRAM OF THE VETERANS ADMINISTRATION

WHEREAS, the Veterans Administration has initiated the Geriatric Research, Education and Clinical Centers program (GRECCS) to meet the needs of the growing population of aging veterans, as enhanced by Public Law 96-330; and whereas, this program represents a focal point for the research, personnel training, and program development efforts of the Veterans Administration in its preparation for meeting the increased needs of the aging veteran; and whereas, this program also represents one of the most advanced and comprehensive efforts in the Nation to better understand and accommodate the needs of the aging; and whereas, this program must be expanded and accelerated as the aging veterans population increases, while, at the same time, the Veterans Administration must retain its commitment and its services to meet the needs of acute health care and of the disabled veteran; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that Geriatric Research, Education and Clinical Centers of the Veterans Administration be enhanced and expanded, and provided with adequate funding to meet their responsibility.

- Resolution Number 11

TO PROVIDE FOR ADEQUATE FEDERAL REIMBURSEMENT FUNDS FOR STATES' PROVISION OF SERVICES TO VETERANS

WHEREAS, state departments of veterans affairs and their state veterans' homes provide for health care, domiciliary, and other services to veterans on a reimbursement basis from the Veterans Administration; and whereas, these state efforts include some 43 state veterans' homes in 31 states and the District of Columbia; and whereas, the increased demand for services of aging veterans will include an increased demand for services provided by the states; and whereas, additional reimbursement funds, at an adequate level of cost-sharing, will therefore be necessitated by the increasing population of aging veterans; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that adequate funds, at adequate cost-sharing levels, be provided within the budgets of the Veterans Administration to provide for services to veterans through reimbursement of these funds to the states.

- Resolution Number 12

TO PROVIDE FOR ADEQUATE FEDERAL MATCHING FUNDS FOR THE EXPANSION OF STATE VETERANS' HOMES

WHEREAS, state veterans' homes in 31 states and the District of Columbia provide more than 15,000 domiciliary and nursing home care beds which complement the Veterans Administration health care system in meeting the needs of aging veterans; and whereas, an increasing population will generate greater demand on these state veterans' homes to provide such health and domiciliary care for the aging veteran; and whereas, planning, modernization, and new construction of such state veterans' homes is predicated on the availability of Federal matching funds; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that Federal matching funds for construction and modernization of state veterans' homes be continued and expanded within the budgets of the Veterans Administration, at funding levels appropriate to meet the future demands of the aging veterans population.

- Resolution Number 13

TO ENACT LEGISLATION AUTHORIZING RESIDENTIAL CARE INVOLVEMENT BY THE VETERANS ADMINISTRATION

WHEREAS, nearly 14,000 veterans are currently in private residences or in facilities that provide personal care and supervision, at the veteran's personal expense; and whereas, the Veterans Administration monitors the veteran's adjustment and progress in such circumstances, and annually inspects such residence or facility at the permission of the owner; and whereas, the Veterans Administration provides this ongoing residential care monitoring and inspection solely at the goodwill and permission of the owner, with correction of any deficiencies the decision of the owner; and whereas, Veterans Administration sanction for such residential care involvement is implied in its statutory authority to provide medical care and to ensure the safety and well-being of veterans, but, is not specifically authorized by legislation; now, therefore:

BE IT RESOLVED, that the 1981 Veterans'.Conference on Aging recommends that the White House Conference on Aging and veterans service organizations seek legislation to specifically authorize a program by which the Administrator of Veterans Affairs may transfer or place veterans from VA medical facilities into such residences or facilities in the community and then participate in their care through monitoring, medical advice, and inspection.

- Resolution Number 14

TO ENHANCE AND INTENSIFY VETERANS EMPLOYMENT SERVICES FOR DISABLED AND OLDER VETERANS

WHEREAS, the growing population of aging veterans in the work force presents special problems as disabilities become more restrictive because of aging; and whereas, continuation of work for disabled and older veterans further ensures their security in older age and also further ensures their viability and active life; and whereas, the responsibility for providing specialized services to accommodate the employment problems of disabled and older veterans is vested with the U.S. Department of Labor and its Veterans Employment Service , and to state employment agencies; and whereas, the increase of older and disabled veteran workers will need/require more assistance and guidance from employment service entities; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that services to disabled and older veteran workers be enhanced and intensified by the U.S. Department of Labor and the state employment agencies; and

BE IT FURTHER RESOLVED, that veterans service organizations are encouraged to seek adequate funding for employment services by the Congress.

- Resolution Number 15

TO PROVIDE FOR RECRUITMENT OF OLDER VETERANS IN FEDERAL PART TIME EMPLOYMENT PROGRAMS

WHEREAS, older veterans constitute an experienced and capable work force, but are underutilized as a resource by the Federal work force; and whereas, many disabled veterans must leave the full time work force early due to disabilities worsened by the aging process, but who remain capable of working part time; and whereas, programs have been established by the Federal government to target older Americans as potential supplemental part time workers; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that veterans service organizations seek enactment of legislation by the Congress and implementation of a program by the Office of Personnel Management to ensure extensive recruitment of older veterans in part time employment programs.

- Resolution Number 16

TO DESIGNATE THE SECOND FULL WEEK OF MARCH AS NATIONAL "EMPLOY THE OLDER WORKER WEEK"

WHEREAS, numerous difficulties are encountered by the older worker in employment, retention and mobility, including the significant number of older workers who are veterans; and whereas, many of the problems encountered by older workers are based upon public attitudes and general misunderstandings about the abilities and contributions of older workers; and whereas, such problems are compounded for the older veteran because of complications brought on by the aging process; and whereas, recent years have seen some reform in attitudes about older workers, and about timing of retirements because of age, including legislation which prevents discrimination because of age; and whereas, greater awareness of employers and the general public can help remove some of the difficulties encountered by the older worker, and as well inform the older worker of certain rights and services related to employment; and whereas, veterans who are older workers, especially those with disabilities, could benefit from removal of such difficulties; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that the White House Conference on Aging seek to establish an annual national "Employ the Older Worker Week," during the second full week of each March, as a concerted effort to remove barriers confronting the older worker in the Nation.

- Resolution Number 17

TO ENSURE TAX-EXEMPT STATUS OF SOCIAL SECURITY AND VETERANS BENEFITS AS WELL AS PROTECTION OF THE INTEGRITY OF THE VETERANS ADMINISTRATION

WHEREAS, the 1979 Advisory Council on Social Security recomended that one-half of an individual's Social Security benefits be reported as taxable income for Federal Income Tax purposes; and whereas, the Congressional Budget Office has also identified taxation of Social Security benefits as a means of reducing Federal expenditures; and whereas, taxation of Social Security benefits could be in effect a reduction of Social Security benefits and a contractual violation between the Federal government and the People; and whereas, the aging beneficiary, when in greatest need of the minimal support provided by Social Security at a time when health and other expenses are higher, would be detrimentally impacted by taxation of these benefits; and whereas, taxation of Social Security benefits would serve as precedence for the Federal government to tax veterans entitlement programs; and whereas, from time to time various proposals and plans are presented to merge jurisdiction and administration of veterans programs and services under the administration of other Federal agencies besides the Veterans Administration; and whereas, it is the consensus that the Veterans Administration must be continued as the single agency for the administration and execution of veterans benefits and services programs provided by law for aging veterans; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that the White House Conference on Aging and veterans service organizations express their total opposition to the taxation of Social Security and/or veterans benefits; and

BE IT FURTHER RESOLVED, that opposition likewise be expressed to any efforts, from whatever source, that would transfer any of the programs and services of the Veterans Administration to another Federal agency.

- Resolution Number 18

TO PROVIDE FOR AN ADEQUATE CEMETERY AND BURIAL BENEFITS PROGRAM FOR VETERANS

WHEREAS, the National Cemetery System provides for over 100 cemeteries for interment of veterans in a location which recognizes and honors their service to their Nation; and whereas, there are numerous state veterans cemeteries for similar purposes of recogntion and honor; and whereas, there are certain minimal benefits that a widow(er) of a veteran may obtain to ensure a proper funeral for a veteran; and whereas, the coming decades will witness an increased demand of cemeteries and benefits to ensure burial of veterans in dignity; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that Federal and state veterans affairs entities provide adequate grave sites to ensure honor and dignity at a veteran's death, in recognition of his or her service to the Nation in the Armed Forces.

- Resolution Number 19

TO ENHANCE THE WHITE HOUSE CONFERENCE ON AGING DURING THE 1981 INTERNATIONAL YEAR OF DISABLED PERSONS

WHEREAS, the 1981 Veterans' Conference on Aging has initiated emphasis on the aging veteran; and whereas, this Conference represents a focal point on the aging veteran nationally; now, therefore:

BE IT RESOLVED, that the 1981 Veterans' Conference on Aging recommends that the Federal Interagency Council of the American Committee of the International Year of Disabled Persons address and give emphasis to the issue of aging disabled veterans in its observation of the 1981 International Year of Disabled Persons.

STATUS OF RECOMMENDATIONS

These nineteen recommendations address concerns and recommendations of the veterans' community about aging veterans and older Americans. Collectively these 19 Resolutions serve as a first major effort to emphasize aging affairs within the veterans affairs field by an alliance of veterans service organization officers and staffs. As time passes, and the veterans' community further analyzes the issues and the legislation, additional recommendations by respective groups and by groups in concert will surface. The status of these Resolutions among the veterans organizations is one of suggestion to the White House Conference on Aging, the Congress, the Federal government, the private sector, and the veterans organizations themselves. In essence, these Resolutions identify the issues and recommendations at the initial review by the veterans' community on the subject of veterans' aging.

THE VETERANS ADMINISTRATION

A number of the Resolutions of the Veterans' Conference on Aging addressed the Veterans Administration more so than the White House Conference on Aging. Why is this so, when mini-conferences are part of the WHCOA process? There are two reasons why the veterans service organizations addressed the VA and its programs within the context of this report to Delegates and Observers of the White House Conference on Aging.

First, the VA is one of the significant providers of health care and other services to the aging population of the Nation. In Fiscal Year 1980, over 378,000 aging veterans were treated in 172 VA hospitals, 92 VA nursing homes, 16 VA domiciliaries, 41 State homes, and numerous contract hospitals and nursing homes. In addition, aging veterans made over 3 million visits to 226 VA outpatient clinics and to fee basis non-VA physicians. In essence, the VA carries a good portion of the health care services rendered to all aging citizens. In addition, the VA provides a veterans pension program for 1.8 million veterans in lower income brackets, and disability compensation for 2.3 million veterans with service-connected disabilities. These entitlements ensure a better standard of living for a very large number of older Americans who are veterans. The point is that the VA is one of the key human service delivery systems of the Federal government, and its programs and benefits assist aging veterans and therefore a major segment of the aging population of America.

Second, the Veterans Administration is a leader in the field of medicine. It is the largest health care system in the Free World, with 172 medical center complexes and additional outpatient centers found throughout the country. More than 100 of these hospital complexes are affiliated with and serve as teaching centers for the Nation's medical schools. Recently, two VA scientistsreceived Nobel Prizes for Medicine, indicative of the advanced nature of VA research and medical expertise. The 96th Congress passed Public law 96-330, which enhanced the Geriatric Research, Education, and Clinical Centers program in the VA. These centers are fast becoming a focal point for the application of medical expertise, research and systems planning and management to accommodate the needs of the aging. Much of the future of serving the health care needs of the elderly will result from the scientific inquiry, professional training, and insights gained from these Geriatric Centers of the VA today. The results and the progress of these Centers will not only contribute to the well-being of veterans, but also to a better and more comfortable life for all older Americans.

Thus, White House Conference on Aging awareness of and support for the Veterans Administration's health care and benefits system can help secure quality service for millions of veterans, and can pay rich dividends for all older Americans through the advancement of medical technology and medical training.

SUMMARY

The veterans' community is proud to become a part of the White House Conference on Aging, and to join with the other fields of discipline and the other constituencies of aging Americans, in this important 1981 effort to set a national agenda for serving older Americans in the 1980's and the 1990's.

We have a constituency of millions of aging veterans and their spouses and widow(er)s who are increasingly interested in the affairs and workings of the field of aging, and we have over ten million veterans who are members of veterans service organizations and who are prepared to support initiatives to serve the aging veteran and the aging American.

We look forward to playing a greater role in the field of aging in the months and years ahead, and becoming partners with others committed to the pursuit of a society in which age is no barrier to living a full, complete and comfortable life.

ACKNOWLEDGEMENTS

The Veterans' Conference on Aging expresses its appreciation to the following members of the Executive Committee for their work and dedication to its implementation: William G. (Bill)Fisher, Conference Chairman and National Commander, Veterans of World War I of the U.S.A.; Norman B. (Gabby) Hartnett, Conference Resolutions Chairman and National Director of Services, Disabled American Veterans; Paul L. Weston, Conference Coordinator and Deputy Director, White House Veterans Coordinating Committee; Beulah Cope, Conference Treasurer and National Adjutant, United Spanish War Veterans; James Bourie, National Economic Commission Director, Thomas M. Schneiders, National Veterans Affairs and Rehabilitation Commission Assistant Director, and F. Edward McDonald, Chief of Field Service , all of the American Legion; Gabriel Brinsky, National Service and Legislative Director of AMVETS: Ronald W. Drach, National Employment Director, and Charles A. Thompson, Administrative Assistant, both of the Disabled American Veterans; Frederico Juarbe, Jr., Director of National Veterans Service, and Frank Conlon, Field Representative, both of the Veterans of Foreign Wars of the U.S.; and, Dr. Paul A.L. Haber, Assistant Chief Medical Director for Extended Care, Robert W. Abel, Program Planning Specialist, and James J. Cox, Director of Veterans Assistance Service, all of the Veterans Administration. In addition, the Conference is grateful for presentations by Congresswoman Margaret M. Heckler of Massachusetts and Congressman Claude D. Pepper of Florida; National Commander Michael G. Kogutek of the American Legion; National Commander-in-Chief Arthur Fellwock of the Veterans of Foreign Wars; and the many talented professionals from the Senate and House Veterans and Aging Committees and from the Federal agencies who were able to participate in the Conference. Additional appreciations go to Usha T. Keene, Conference Secretary; and to Joan Buchanan of the White House Conference on Aging.

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the 1981
White House
Conference
on
Aging

Report of the Mini-Conference on "The National Dialogue for the Business Sector"

MCR-29

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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SPONSORS BACKGROUND

The EXECUTIVE BOARD is an independent, non-profit corporation based in Phoenix, Arizona. The BOARD serves as a Center for Issues Analysis, working closely with senior executives to assess the significant economic, political, social and technological developments affecting the business environment.

The EXECUTIVE BOARD is affiliated with the Western International University, a private, non-profit accredited university located in Phoenix, Arizona. Its programs are designed to meet the evolving needs of the Business Sector.

The WESTERN GERONTOLOGICAL SOCIETY (WGS), a non-profit, membershop association, has served elders and those working with and for elders, since 1954. WGS is dedicated to the preservation and enhancement of independence and dignity into advanced older age. It links researchers, practitioners, older people, and most recently, business leaders into a mutually beneficial and supportive network working toward that end. Through its programs and services, WGS facilitates opportunities for communicating information, developing new service and research strategies and advocating for substantive policy issues. The Society's President - Carl Eisdorfer, Ph.D., M.D. - is a distinguished gerontologist, scientist and physician.

ADDITIONAL SUPPORT PROVIDED TO THE DIALOGUE

The Western International University provided advance funding assistance to the Dialogue.

The Atlantic Richfield Company provided their Conference Planning staff to assist with the logistics of the La Quinta meeting.

The Edison Electric Institute hosted meetings for the Planning Group and the National Business Organizations.

The German Marshall Fund contributed funds for the expenses of the European speaker, William Robbins.

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I INTRODUCTION

The dramatic changes occurring in the size and nature of the U.S. population are projected to continue well into the 21st Century (Figure 1). They have already created critical policy issues for government. They have spawned a fast-growing field of "Aging", and large and powerful interest groups representing the over-55 population. The demographic changes are so profound and far reaching, that no one -- individuals, families, communities, the private and public sectors -- will escape the effects. These changes will test the moral, societal, and economic fabric of the nation. They will certainly challenge the traditional concepts and approaches of the corporation toward employment and work practices, benefits and entitlements.

As government seeks to realign and reallocate resources to meet the growing needs of the older population, it is turning to the business sector to assume a larger role and a greater share of the burden. This sector is critical to the well-being of the nation. It has provided the technological and economic base upon which America has achieved its remarkable standard of living. Its success has not only contributed to the stability of the nation, it has enabled social support programs to be considered and implemented, largely through its tax contributions. Most importantly, the business sector is an integral part of our lives, from the small town to the city, from the home to the workplace. Its policies and practices affect the lives of millions of Americans. The business sector will play a significant role in charting future directions of the society.

Recognizing these factors, the 1981 White House Conference on Aging commissioned a mini-conference for the leadership of the corporate community, "The National Dialogue for the Business Sector," under the sponsorship of The EXECUTIVE BOARD and the Western Gerontological Society. Previous White House Conferences on Aging in 1961 and 1971 had no significant input from business, and the 1981 White House Conference on Aging wisely recognized the value of business participation in its public policy process. Business itself recognizes the need for creative, humane, cost-effective solutions to problems caused by the aging of the population.

In the coming decade, the Business Sector will face a new range of opportunities and/or threats directly linked to the dramatic change in the size and nature of the over-55 population. Not only will these developments impact upon existing markets, both at home and abroad, they will generate a whole new set of internal and external sociopolitical and economic pressures. If companies ignore the related critical policy issues or do not deal with them effectively, the inevitable will occur, i.e., pressures will lead to government actions in response to legislative and labor demands. In his address to the Dialogue, Dr. Carl Eisdorfer, noted physician and gerontologist warned:

"There is no way that corporate life in the United States or throughout the world is not going to be affected by the profound increase in the longevity of people and the major shift in resources required to meet their needs, particularly in areas like health. If we let the government do it, then I think we shall be faced with minimal standards, a large and complex bureaucracy, a leveling effect, and, in all probability, a reduction of options. Government rarely gives options. It's the Corporate Sector that offers the opportunity to develop unique options."

Since 1973 the reality of limited resources and growth has raised the spectre of a reduced standard of living in America at a time when the working population had developed its highest set of expectations and entitlements regarding retirement. There also emerged, following these events, a renewed public concern over government regulations and involvement that was partly responsible for the election of a new administration in 1980. America's corporations, while being relieved of some of the burden of government regulations, face new dilemmas as government attempts to shift more of the financial responsibility of maintaining an older population to the private sector. These challenges occur in an era when U.S. Corporations face severe competition worldwide, lowered productivity at home, and new pressures to rebuild industrial capacity. Thus the questions are raised, "How should the responsibility be shared in assuring the economic well-being and security of the older population? How should existing resources be allocated, given the stresses on the economy?"

Business executive, Robert O. Anderson, co-chairman of the Dialogue, reminded participants:

"The American business system has, in the past, proven itself both creative and resilient, able not only to survive change but to initiate change in ways that benefit individual enterprises and the country at large. The aging of America will bring change to all aspects of business. How well we deal with this change will be determined by the imagination, generosity, and hard-headed business sense we bring to bear on the problem. This Dialogue gives us a perfect opportunity to begin."

II DIALOGUE BACKGROUND

The National Dialogue for the Business Sector which was held in La Quinta, California, March 5-7 brought together senior executives from more than 60 American Corporations. The Dialogue, the first conference of its kind, was organized by The EXECUTIVE BOARD, a Business Environment Analysis Center associated with Western International University, Phoenix, Arizona. It was sponsored by The EXECUTIVE BOARD and the Western Gerontological Society.

Funding was provided by The White House Conference on Aging, the Corporation for Older Americans, Atlantic Richfield Company (which also provided in kind assistance), International Business Machines Corporation, I.T.T. Continental Baking Company, Prudential Insurance Company of America, Standard Oil Company of California, Sun Company, Fluor Corporation and The German Marshall Fund.

Corporate Executives representing a cross section of American Business paid their own expenses while The Dialogue sponsored the non-corporate resource participants.

Discussion topics for the Dialogue were carefully selected following thorough consultations with senior business executives, human resources managers, national business organizations, specialists from the major policy and research institutes, gerontologists and the Dialogue planning group.

Working briefs were commissioned for each workshop. These set forth the principal dilemmas and options for each issue as well as a list of the major groups addressing the issues, and the official positions of these groups.

The Dialogue addressed four major areas within a business context and raised these specific questions:

WORKFORCE/PRODUCTIVITY - What impact will an aging workforce have on productivity? How can the corporation strengthen its competitive position while responding to (1) changes in the composition and nature of the workforce; (2) in retirement age and age-discrimination legislation and (3) in employee expectations regarding training, education, health programming, life planning, and retirement options?

HEALTH - What options exist for dealing with the rapidly escalating costs of health care related to an aging workforce and the changing ratio of retirees to active employees?

PENSIONS AND SOCIAL SECURITY - What options does the corporation have for responding to the rapidly rising cost of pensions, Social Security and other government-mandated programs? How does business address this issue in light of the deterioration of existing pension programs in an inflationary economy, and new pressures on the corporation to meet the heightened "welfare and security" expectations of the workforce?

THE MARKETPLACE - What impact will the over-55 population have on the marketplace as consumers, owners and as a political force. To what degree should future research and development be directed to new products, product adaptation, and services for this age group?

III THE DIALOGUE

Robert O. Anderson, Chairman of the Board of Atlantic Richfield Company, and Marshall McDonald, Chairman of the Board of Florida Power and Light Company, co-chaired the Dialogue and participated in the discussions. Mr. Anderson formally opened the Dialogue, and focused his remarks on, "Off the Shelf: New Opportunity for Older Americans." Mr. McDonald addressed "The Aging of America: Implications for Corporate Policy." (The text of both these speeches appears in the appendix of this report).

The participants gave thoughtful and serious attention to the issues, as demonstrated by the sharpness of their comments recorded in this report. They welcomed the opportunity to share views and opinions, not only with their colleagues, but also with policy makers from adversary and advocacy groups.

The Dialogue has reinforced the value of assembling policy level Executives from various industries in a "risk free" forum which encourages diverse opinions to surface and the issues to be addressed in broad socio-economic dimensions.

Dialogue invitations were extended to policy-level executives of major U.S. corporations, in recognition of the key role these companies play in the public and private sectors. Invitations were also extended to several smaller companies. Corporate participation was limited to senior policymakers since the issues discussed demand significant corporate policy choices and actions.

A format of panel debates, workshops and plenary discussions helped to stimulate the forthright expression of opinions, and to clarify corporate perspectives on the issues. Background presentations offered insight into the phenomenon of the aging of the population as well as the basic assumptions and key expectations of government and labor. They also exposed the societal and ethical questions implicit in the economic issues.

These background presentations, combined with the Co-chairmen's addresses, set the stage for the Dialogue discussions. They are summarized in the following pages.

IV BACKGROUND PRESENTATIONS

IV-A "THE PSYCHOLOGICAL AND BIOLOGICAL ASPECTS OF AGING AS THEY AFFECT THE DYNAMICS OF THE CORPORATION". (Highlights of a paper presented in plenary session by Dr. Carl Eisdorfer, President Montefiore Hospital and Medical Center, Bronx, New York)

Modern research is demolishing many myths about aging -- that the abilities of older people invariably are in serious decline, that older workers are slow learners, that their minds do not function well, that they are disengaged and apathetic, that they are frail and unable to stand stress, that they "cause problems" for employers and are no longer productive. These generalizations can be dangerous and counterproductive. New knowledge about this very rapidly growing segment of the population suggests that all American institutions, including business and labor, should re-examine many traditional attitudes and beliefs. The growing body of evidence indicates that, far from presenting a "problem" for the nation, the elderly present the nation with an opportunity. Instead of being a liability, older people are a valuable human resource that America can no longer afford to waste. Age is the only condition toward which we are bigoted yet to which we all desperately aspire.

The predominant myth that old age is nothing more than a period of functional loss is bolstered by a misinterpretation of the fundamental biological fact that aging is accompanied by the loss of body cells. It is known, for example, that the number of cells in the central nervous system does decrease with age. What is all too often ignored, however, is the great redundancy of cells in the central nervous system. The human brain has an over-supply of billions of nerve cells so that their loss through life is not at all synonymous with a loss of mental ability. Furthermore, experience is a major offset even to physiologic loss, i.e., the use of older astronauts in this regard. What is more important in determining the functional ability of an older person is not how many cells a person has lost over a lifetime, but rather what is present and the state of physiological integration which exists between the various organs and cells. Since individuals vary greatly in the rate at which they lose this physiological integration, it is simply inaccurate to regard all old people as being in a process of rapid decline and diminishing usefulness.

An especially pernicious myth is that senile dementia and other diseases are inevitable if one lives long enough, for it implies that older workers must be taken out of the labor force before they "make a mess of things." It is true that many diseases are more common among older people, but these are by no means inevitable for the majority of older workers and it must be recognized that a strong tendency exists for older workers to select themselves for retirement when they do not feel well, provided they can afford to retire. There simply is no biological basis for mandating retirement for all who reach a certain age. It is productivity, not gray hair and wrinkles, that needs to be examined.

Another myth is that old people are unable to handle stress. It is important for managers to remember that older people are survivors, indeed their survival attests to their ability to manage stress successfully. Their experience, in many ways, allows them to deal more successfully with the stresses of life than younger persons.

If the nation persists in believing old myths, seeing older people in a negative light, not using them productively, and putting them "on the shelf" merely because of age, nearly one in five Americans will be dependent, or close to it, in a few decades, and a major shift of resources will be required to care for them. Already, health care costs in the United States are about 10 percent of the gross national product (most of the costs are for hospital care), and the elderly account for a disproportionate share of these costs.

It is, therefore, naive for corporations which are contributing vast sums directly to health benefits and to other human services through taxation, to think they do not have a stake in the costs of maintaining the health and productivity of an aging population. Industry can either develop plans to make productive use of older people, or pay more taxes so that governments can care for them. In either case, the corporation has to pay.

Traditions of the private sector that are barriers to the effective use of older people must be examined. One such tradition is the view of corporate life as a "ladder" to climb: early in life one gets onto the bottom rung and moves upward, only to fall off when the top is reached and never to be heard from again. A "lattice" might be considered as a more appropriate model for an aging workforce. A lattice, by allowing movement in all directions on the basis of an individual's changing interests, abilities, and talents, would allow maximum individual growth and contribution while minimizing the impact of negative stereotypes.

Another important role of the older worker in the corporate setting that can be enhanced is that of teacher and role model for younger workers. A thorny question is involved in using an older worker in this way; however, can a worker whose primary loyalty may be to a union also function comfortably in the role of socializing younger workers to the values and needs of the corporation? The answer depends on how well management and labor can cooperate in dealing with the issue of loyalty to whom and for what purpose.

Older workers need continuing education and training to stay productive. Though they are a repository of vast experience and talent, we concentrate all of our education and training resources on the young. In doing so, we push older people out of the central information pool and, thereby, create a kind of forced obsolescence. This pattern is as wasteful as buying a new car, filling the tank with gasoline, then abandoning the car when the tank is empty.

Another important task corporations should consider is preserving older workers' identification with the corporation after retirement -- by preparing them for retirement, even offering them training for other occupations and then using this talent pool on a fee-for-service basis.

Negative stereotypes about older workers, our American "youth culture," and traditional hiring practices that discriminate against the elderly are among the major forces that tip the scale toward restraining the extension of working life. However, several powerful forces are at work that are likely to alter the balance in the other direction. These include the rapidly rising cost of Social Security, the need for corporations to retain the talents of older workers, and the economic and psychosocial needs of older workers to stay on the job. (Figure 2.)

The cultural stereotype of the older person as helpless, hopeless, and decrepit is a form of bigotry. As with the racism, the damage arises not only from what the majority feel about the minority, but from what the minority are made to feel about themselves.

The stereotype is self-fulling: Older people accept the prevailing myths that they are infirmed, that they can only deal with their problems medically, that they have to function in ways that make them seem old. Corporate leaders have bought the myths of agism, too, although the psychological mechanisms of denial usually prevent individuals from applying such beliefs to themselves ("everybody is alike except I'm different"). We must all realize that by perpetuating agism, we, too, are likely to become its victims, if we live so long.

This approach should not be considered "pie in the sky." The demographics and economic changes are highly predictable, at least for the next three or four decades. The data are there, and the alternatives may be readily ascertained by anyone with the wisdom to address the issues. We either face the significant personal and social problems of a burdensome and dependent older population or we alter our way of doing business to position ourselves to deal with the changing population and the opportunities it presents. Once again, the choice is in our hands.

IV-B "THE EXPERIENCE OF EUROPEAN CORPORATIONS"

(Highlights of a paper presented in Plenary Session by William Robbins, Director, Personnel, Imperial Chemical Industries - Europa, Brussels, Belgium)

Western Europe and the United States are experiencing similar demographic changes. European countries, therefore, face many of the same problems arising from the growth of the older population that this country does. However, their approach to these problems is quite different. In general, there is very little serious discussion in Europe about growth of the older population and the associated cost.

In contrast to the United States, the question of abolishing mandatory retirement age is not on the political agenda in any European country. There are three basic reasons for this: (1) European political systems and social values make it far more difficult for pressure groups to affect established political parties; (2) European Social Security systems, much older than the American Social Security system, have extended the amount and range of benefits to a far higher level since World War II, and are, therefore, a much more important part of the total provision for retirement (see Figure 3); and (3) there is greater concern about unemployment, especially youth unemployment which has risen since 1974 to equal or even exceed U.S. levels and is regarded by most European countries as their most pressing social problem.

High unemployment among European youth has shifted both government and corporate attention to early retirement as a solution. Usually, the emphasis has been on voluntary early retirement, but in many situations the degree of voluntarism is low. For example, government aid to rescue ailing business often is given on condition that older workers be retired early, often as early as age 55. Although this approach effectively redistributes unemployment toward older workers, there has been no significant outcry that the practice is socially unjust. Indeed, a significant proportion of workers in many European countries strongly favor early retirement (Figures 4 and 5). This may be due partly to the fact that many early retirees supplement their retirement incomes by moonlighting in the so-called black economy, the fastest growing segment of the economy in many European countries.

Most European schemes for early retirement feature high benefit levels. In Belgium, workers over 60 who are retired for economic reasons receive half the difference between the rate of unemployment benefit and their net earnings, subject to a salary ceiling that continues until the normal state pension age of 65. In Denmark, workers 60 or older who voluntarily give up their jobs receive 90 percent of their average earnings for two and a half years, 80 percent for the next two years, then 60 percent until they reach the normal pensionable age of 67. In France, workers 56 and 3 months of age, who are retired for economic reasons, receive 90 percent of their final salary for one year, then 45 percent until age 60, after which they receive 70 percent of final salary revalued for increased cost of living since retirement. West Germans who retire early at age 59 can draw a high unemployment benefit until age 60, then receive the full state pension if they have a contributory record of 35 years.

In countries where the level of government protection is not that high, for example, the United Kingdom, many corporations use early retirement as a way to ease their financial difficulties. In theory, early retirement is voluntary in such companies, but the reality is that pressure from management and from colleagues results in few people staying on the job until normal retirement age.

Will the pressures that exist in the United States appear in Europe? Probably not in the short run. However, two factors are operating that eventually may lead to some convergence in American and European thinking. First, demographic projections show that after 1990 the European Economic Community's working age population will fall, and its older population will rise to comprise an even higher proportion of the total population than in the United States. Second, European Social Security systems are becoming increasingly strained; the Belgian state pension system, for example, is almost bankrupt. (Figure 6 shows the range of employer and employee contributions to state Social Security for all purposes. Figure 7 indicates the high proportion of national income which is going to Social Security and other state expenditures). Eventually, European countries will have to reconsider their policies, especially on early retirement. At the present time, however, there is little perception in Europe of the major problems that will have to be faced later in the century. Could the United States avoid the problems besetting European state-run systems by giving corporations a greater role in providing for the health and retirement income of the aged? Unfortunately, the problems involved in these areas are beyond the capacities of the business sector to solve. A national public system is needed, but that system must be kept within the bounds of economic reality.

V A LABOR AND GOVERNMENT PERSPECTIVE

Labor and government perspectives were presented in two background presentations, both of which are summarized in the following pages in the form of assumptions, and expectations of the corporate sector. A labor perspective is drawn from the address by Howard Samuel, President of the Industrial Union Department, AFL/CIO, and does not necessarily represent all labor views. A government perspective is summarized by Representative Claude Pepper, Chairman of the House Select Committee on Aging. The views of the current Administration were presented in the panels and workshops by individuals who are serving as advisors to the current Administration and by many of the corporate participants. They are reflected in the recommendations and in the sections on Dialogue Comments and Corporate Concerns.

V-A A LABOR PERSPECTIVE: Howard Samuel, AFL/CIO

ADEQUACY OF RETIREMENT INCOME - ASSUMPTIONS :

- Adequate retirement income is an obligation of society and an expression of our most ancient ethical and religious principles.
- "Adequate" implies an entitlement commensurate with the pre-retirement standard of living and generally means 65-85 percent of pre-retirement gross income.
- Personal savings are unlikely to contribute significantly to post-retirement security and income for many workers.

ADEQUACY OF RETIREMENT INCOME - EXPECTATIONS:

- Labor expects the business sector to be committed to the preservation and selective expansion of social legislation and tax policies that facilitate the economic well being of older Americans.

SOCIAL SECURITY AND PENSION SYSTEMS - ASSUMPTIONS:

- Social Security as a universal system is the most feasible, stable, and fairest way to combat income inadequacy in retirement.
- The funding crisis of the Social Security system is short-term.
- Private pension plans have flourished because of favorable tax treatment for employers. Similar incentives for employees would not motivate those at or below average incomes, demonstrated by extremely low participation in Individual Retirement Account programs.
- The performance of pension funds has been dismal, and their investment criteria have been self-defeating.

SOCIAL SECURITY AND PENSION SYSTEMS - EXPECTATIONS:

- Labor expects the business sector to share the belief that the Social Security system and private pensions are the major components of retirement security.
- Labor expects the business sector to share the belief that emphasis must be placed on Social Security and that it be funded on an interim basis from general revenues.
- Labor expects the business sector to work to perfect the process of pension portfolio management and to involve labor actively in fund management decision processes.

RETIREMENT AGE - ASSUMPTIONS:

- Most workers do not see their work as their principal avenue of self-fullfillment.

- Without full employment, workers should not be encouraged to stay on the job because it would limit considerably the ability of the young and the unemployed to enter the workforce.

RETIREMENT AGE - EXPECTATIONS:

- The business sector should not support postponing the age at which workers can collect Social Security.
- The business sector should not encourage older persons to stay on the job unless they want to.

GOODS AND SERVICES FOR THE ELDERLY - ASSUMPTIONS:

- The aging population will need goods and services not presently available, including specialized health care and recreational facilities.

GOODS AND SERVICES FOR THE ELDERLY - EXPECTATIONS:

- The business sector should recognize both the opportunities and the responsibilities associated with the aging of the population.

V-B A GOVERNMENT PERSPECTIVE: Rep. Claude Pepper (D) Florida

ADEQUACY OF RETIREMENT INCOME - ASSUMPTIONS:

- All older Americans deserve an adequate and satisfactory income which ensures a comfortable standard of living.
- The large number of elderly individuals near or below the official poverty line is a national tragedy that requires immediate resolution.

ADEQUACY OF RETIREMENT INCOME - EXPECTATIONS:

- The business sector should develop private initiatives (pensions, savings) and support legislative programs designed to substantially improve the future retirement security of all Americans.
- The business sector should support retirement income security programs that are especially sensitive to the most needy among the population, while at the same time preserving equitable financial incentives for all groups and expanding investment capital for the nation as a whole.

SOCIAL SECURITY, PENSION SYSTEMS AND RETIREMENT SAVINGS ASSUMPTIONS:

- Retirement income is based on the concept of a three-legged stool Social Security, pensions and private savings, and all three legs should be further strengthened.

- Social Security is the bulwark of the retirement income system and its financial integrity and fundamental principles should be retained and reinforced.

- The long- and short-term financial difficulties faced by the Social Security system can be resolved responsibly without jeopardizing the retirement plans of older Americans, but further expansion of the system will be difficult due to public resistance to increased taxes.

- The private pension system has expanded because of favorable tax treatment, but its lack of coverage of nearly half of the workforce necessitates further government action to increase pension protection.

- Retirement savings have benefited only the wealthiest segment of the population, but with appropriate tax incentives low and moderate income persons could be encouraged to increase their savings behavior substantially.

SOCIAL SECURITY, PENSION SYSTEMS AND RETIREMENT SAVINGS - EXPECTATIONS

- The business sector should continue to support the Social Security system as the most efficient means of meeting the basic income needs of older Americans.

- With proper incentives from government, the business sector should willingly increase pension coverage for all workers by lowering vesting standards and developing coverage where none presently exists.

- The business sector should not waste productive potential nor jeopardize the economic stability of pension funds by encouraging early labor force withdrawal using non-actuarially reduced early retirement incentives.

RETIREMENT AGE - ASSUMPTIONS:

- Work is a critical source of income and fulfillment for individuals of any age.

- All members of society should be granted equal employment opportunities, and under no circumstances should the job of an older person be taken away to make room for a younger person.

- Attempts to keep older workers on the job longer should rely on the use of economic and social incentives rather than mandatory increases in the entitlement age for retirement benefits.

RETIREMENT AGE - EXPECTATIONS:

- The business sector should eliminate all age biases in personnel policies and practices and allow older persons to move freely in and out of the labor force free of discrimination.

- The business sector should eliminate all disincentives to delayed retirement and should make early retirement incentives more realistic.

- The business and union sectors should encourage greater job flexibility to enable older workers to remain employed longer without forcing them to retire or stay on the job.

GOODS AND SERVICES FOR THE ELDERLY - ASSUMPTIONS:

- The growth of the aging population, especially among the oldest of this age group, necessitates development of innovative goods and services to meet its needs.

GOODS AND SERVICES FOR THE ELDERLY - EXPECTATIONS:

- The business sector should direct its research and development efforts toward products and services that better serve a diverse older population.

VI THE DIALOGUE DISCUSSIONS

William Kieschnick, discussion leader, presented the following assumptions as "givens" to the Plenary Session. Participants did not challenge them and thus they became the underlying theme of subsequent discussions.

VI-A SHARED ASSUMPTIONS

- We will not abandon the elderly. We (the business sector) won't leave our elderly on 'an icy bridge in the winter.' It is in our tradition and cultural heritage not to abandon the aged.

- The Health and Well-Being of Our Older Citizens Is, In Aggregate, Under-financed. The problem is compounding with time; in some areas, the aged are not getting enough from society; while in other areas, they are perhaps getting too much.

- The Social Security system is a social contract of long duration. It is an accepted political reality. It has accumulated political consensus and is worth preserving and making viable. This does not preclude the probability of useful and appropriate amendments.

- Private pension plans should be a fundamental source of retirement income. For the most part, private pension plans are viable, and they are widely accepted in principle and could be extended. They should be a fundamental element in the overall solution to retirement income.

- It is necessary and valuable for individuals to contribute to their own retirement income, both by personal savings before retirement and through extended employment; if they are able.

VI-B IMPLICATIONS: COMMENTS FROM PARTICIPANTS:

- "We aren't going to leave them on an icy bridge because they aren't going to let us. There is no more politically powerful group than the aged, and if we aren't fair in the way we treat them, they can make us behave in ways that might not be good for the economy as a whole. The aged, like the young and everyone else, ought to get a fair deal."

- "It's very easy to say, of course, 'We don't want them abandoned, we don't want them starving, we don't want them to have bad health care.' But we may have to question whether we can meet each and every expansion of benefits and commitments that has been made to the aged over the past decade or so in quite the way we have. Should they be totally exempt from contributing (which will increase the burden for others?)"

- "Should the Reagan Administration leave largely intact programs that directly benefit the elderly (Medicare, Social Security and Supplemental Security Income), rising allocations for defense may require drastic cuts in social programs, or alternatively, increased taxes and inflation to maintain social programs for all groups. It is, therefore, necessary to ask whether the elderly should be totally shielded at the expense of other groups from the effect of these new realities?"

- "There is also tremendous pressure in austere times like these to shift costs to the corporations, to make them pay for social programs through higher premiums, higher payrolls, and higher taxes but all these costs could ultimately reach the public in the form of higher prices."

- "There is no such thing as a free lunch. The growth of the older population is going to cost somebody money, whether it is the government, the corporations, or older people themselves. The task the nation faces is not to pretend we are cutting costs by shifting them, but to find more efficient ways to deliver the benefits the elderly are entitled to. This is a difficult task."

- "To what degree should corporations respond when the workforce turns to them for assurances of their own future health needs, and for help with caring for their elderly family members in order to avoid spending down? (i.e., depleting assets to cover the difference between Medicare payments and medical costs) What, in fact, is the real cost of caring for the aged, what does it take to 'cover the bridge?' As a nation, we are very prone to accept gimmick solutions that purport to hold down costs but in reality only shift them. The decision to limit Medicaid, for example, will not lower costs but will shift them to fall most heavily on the family."

- "One of the myths that needs to be exploded is that families don't care about their aged relatives. That is just absolute nonsense. Most families care so much that by the time the older person goes into an institution the family is drained emotionally and financially, and very often there are family splits. Nobody has really looked at the incremental costs of this kind of stress."

- "It is possible that development of community-based alternatives for long-term health care, for example, helping families take care of their elderly, would be less costly than institutional care. But this requires us to abandon the notion that the burden must be either on the family or on the government and instead to start thinking of new partnerships."

- "Corporations must pay attention to the return on their health investment dollars, particularly hospital costs, and support the development of innovative health delivery systems, especially health maintenance organizations (HMOs). Although HMOs appear to offer a viable cost-effective alternative to the present pay-as-you-go system, they are perceived as loaded with federal regulatory requirements. The fundamental reason why HMOs only serve 4 percent of the population is that the incentive structure favors traditional, private, fee-for-service systems and is heavily weighted against innovative programs."

- "The lack of a CRISIS ATMOSPHERE here at La Quinta is surprising, given the fact that (a) we have a crisis in health care where a third party pays the bills and the party who sells the service determines the level of service or (b) there is a crisis in the pension area, where no one saves for his old age and everything is on a pay-as-you-go basis."

- "The base of the Social Security fund should be expanded by including coverage of federal, state, and local government employees, but the range of benefits should not be expanded. Social Security should be regarded as a 'floor protection.' Older workers should be encouraged to stay in the workforce on a voluntary basis as long as they don't draw Social Security."

- "Some of you should try mining coal or running sewing machines, or standing before an open hearth, or some other odds and ends of the industrial scene. It just takes the need to imagine doing that kind of job for 30 years to realize that for many people it is not the ultimate fulfillment of why they were placed in this mortal world. Thus, if retirement is afforded them, even at age 62, they will take it."

- "People need incentives to make long-term savings for their old age. Letting the earnings in a retirement savings account be tax-free is fine, but it's not much of an incentive for low-income people who don't pay a lot of taxes. Some consideration should be given to the German system of adding a governmental bonus to individual retirement savings accounts that have been maintained for a period of time, say, seven years."

- "The key question evolving is how are we going to generate through supply side economics, the kind of productivity and kind of products that will allow us to meet the kinds of promises we've made?"

VII CORPORATE CONCERNS

In identifing and assessing the implications of meeting the needs of an aging population, Dialogue participants voiced a series of concerns to corporations. These concerns do not represent a consensus, rather they indicate the range of opinion and the participant's perceptions of the nature of the problems that could arise in working to meet the needs. They are summarized below:

Business is concerned that:

- It will be forced to expand its interpretation of social responsibility beyond the traditional "providing the goods and services and the employment of human resources of society in the most efficient, socially acceptable ways that are practically achievable."
- If it does not respond effectively to the issues, someone else will do it for them with results that may be contrary to business interests and a strong economy.
- The adversarial relations of the past between business and government and business and single-issue interest groups, if increased, will limit the ability of business to create opportunities for the advantage of society.
- Increasing social and political pressures will absorb resources and divert attention from the management and operation of the corporation at a time when major corporate initiatives are needed to revitalize many industries.
- The poor performance of some pension fund portfolios will lead to increased involvement of labor in the management of those portfolios, thereby shifting the objective from achieving maximum return on investment to one of implementing social philosophy.
- Traditional attitudes toward age-65 retirement may prevent implementation of programs to encourage older workers to stay in the workforce; it is questionable whether government will develop constructive policies to encourage corporate attempts to keep older workers on the payroll.

- Implementing a policy to determine when an older worker needs retraining could be very troublesome; for example, will an employee or society accept a reduction in pay or responsibility if assessment shows that the employee's capability has slipped below company performance standards?
- The corporation will be pressured to spoon-feed older workers and not hold them responsible for their performance as they do younger workers.
- The corporation's historic inability to participate in the restructuring of public and private mechanisms to provide income security, will persist.
- Corporations are beginning to lose the services of a whole generation of people trained in every conceivable occupation because of existing corporate attitudes and retirement policies.
- The effects of the changing dependency ratio (3 workers for every retiree today, projected to 2 workers for every retiree in the year 2000) will jeopardize all existing retirement programs.
- Some viable options will be excluded from consideration because they do not provide equal benefits for all.
- Government is likely to impose a mandatory pension system on the corporate sector, a dangerous precedent and one that would increase the already high level of social costs borne by the corporation.
- Proposals for faster vesting in pension programs and for pension portability could facilitate employee mobility and thereby erode one of the major benefits of pension programs from the corporate viewpoint, namely, a stable workforce.
- Retaining employees beyond the traditional retirement age would limit the number of career development opportunities for younger workers and make long-range human resource planning increasingly difficult.
- Continually rising Social Security taxes may affect younger workers' attitudes toward the aged and toward their own retirement, as well as their attitude about the adequacy of their own disposable income; this could reduce their productivity.

VIII THE NATIONAL DIALOGUE FOR THE BUSINESS SECTOR RECOMMENDATIONS TO THE 1981 WHITE HOUSE CONFERENCE ON AGING

The recommendations of the National Dialogue for the Business Sector are presented in the following pages. They were taken from the plenary reports of the workshop chairmen and edited with the assistance of those who developed the workshop briefs.

The overviews were drawn from the transcripts of the Dialogue and the plenary and panel discussions. This Dialogue report with its recommendations was circulated to all Dialogue participants for comment prior to submission to the 1981 White House Conference on Aging. The recommendations represent the consensus of participants in the Dialogue.

VIII-A WORKFORCE/PRODUCTIVITY

OVERVIEW:

The composition of the workforce will begin to show significant changes in 1980 as the post World War II "baby boom" generation moves into the 25-44 age group. By 1990, there will be 5 million fewer people in the 16-24 age group, and 5 million more people in the over-65 group. This dramatic shift will create dilemmas for employers already concerned about productivity. The projected shortage of the new entrants into the workforce coupled with the continuing shortage of experienced employees in key skill areas could force employers to find ways of extending the working life of the older employees in order to fill the gaps.

Business Executives taking part in the Dialogue identified management attitude as the key determinant of workforce productivity. This suggested that the problem of productivity of the older worker is more a perception than a reality. Never-the-less, it is a perception that often leads corporations to conclude that early retirement may be the only recourse for workers regarded as no longer productive. More importantly, the worker senses this perception and begins to believe it.

The new techniques evolving in competency assessment need to be carefully utilized in the future to avoid stigmatizing the older worker, particularly when assessment is linked to "retention" rather than performance. Corporations would be wise to ignore age and focus on competency. The role of the skilled worker could be expanded to assist with the upgrading of younger employees.

RECOMMENDATION 1

PRIVATE INDUSTRY SHOULD BEGIN TO UPDATE AND EXPAND EMPLOYEE TRAINING PROGRAMS TO MEET NEW AND CHANGING REQUIREMENTS OF CURRENT EMPLOYEES AND THOSE RE-ENTERING THE WORKFORCE. THESE PROGRAMS SHOULD BE IMPLEMENTED WITH EXPERIENCED AND MATURE WORKERS IN MIND.

Projected shortages of experienced personnel in key skill areas and a continued need to update or modify manufacturing and production methods makes it mandatory that access to retraining opportunities be provided and tailored to the learning styles and capabilities of workers at all ages. New entrants to the labor force, as well as those who re-enter, often discover that corporate training programs are not geared to their learning styles and backgrounds. Older workers may require slightly longer learning times than others, but can and do perform at comparable levels of mastery when given instructions in a format that accommodates their learning capabilities.

RECOMMENDATION 2

GIVEN THE DIVERSITY OF NEEDS EVOLVING AS THE WORKFORCE AGES, MANAGEMENT AND LABOR SHOULD COLLABORATIVELY DEVELOP BENEFIT PLANS TAILORED TO CORPORATE AND EMPLOYEE NEEDS.

The retention and motivation of the mature worker, beyond what is often thought to be the normal retirement age, will require individualized benefit plans that reflect the unique needs of workers whose families have grown up and who may seek options other than maternity benefits. Such packages are now becoming a reality as computers are used as a tool for keeping track of the many permutations and combinations of benefits available. Individualized benefit plans not only will provide selective incentives to employees to continuing working beyond the normal retirement age, but will help insure that their health care needs will be met.

RECOMMENDATION 3

CORPORATE MANAGEMENT AND WORKERS THEMSELVES SHOULD COLLABORATIVELY DESIGN WORK PROGRAMS APPROPRIATE TO THE INTERESTS AND CAPABILITIES OF THE MATURE WORKER.

Job sharing and job rotation, out-placement programs, more part-time work, more flexible working hours, and phased retirement programs would not only help to expand job opportunities they would serve to accommodate worker capabilities and career interests without adding appreciably to the cost of doing business.

RECOMMENDATION 4

CORPORATIONS SHOULD UNDERTAKE INTERNAL CAMPAIGNS FOR THEIR MANAGEMENT AND EMPLOYEES, AND COOPERATE NATIONWIDE WITH LABOR AND GOVERNMENT,ON CAMPAIGNS TO REFUTE THE STEREOTYPIC PERCEPTIONS OF THE ABILITIES AND POTENTIALS OF OLDER WORKERS.

Some employers still view early retirement as a desirable way of getting rid of workers who are above average in take home pay but below the norm in performance (often because they have become trapped in narrow fields of endeavor). The corporations should carefully evaluate the implication of such a policy. If the prevailing view is one of disenchantment with mature worker performance, then that attitude is likely to effect and shape such workers' opinions of themselves, with the result that these expectations become self-fulfilling prophesies.

RECOMMENDATION 5

BOTH PUBLIC AND PRIVATE DONATIONS SHOULD SUPPORT THE ORGANIZATION OF COMMUNITY BASED TEMPORARY EMPLOYMENT PLACEMENT CENTERS FOR THE EXPERIENCED, RECENTLY RETIRED WORKER.

Many retirees are discovering that their income needs and desire to stay active, even on a part-time basis, create a growing demand for guidance and counsel on ways to find appropriate outlets for their talents. Corporate officials, labor union representatives, and government leaders need to jointly plan and implement ways in which information and placement services can be provided.

RECOMMENDATION 6

PAST EMPHASIS UPON A POLICY OF EARLY RETIREMENT SHOULD BE MODIFIED IN LIGHT OF THE CHANGING DEMOGRAPHY OF THE WORKFORCE, TO GIVE EMPLOYEES THE OPPORTUNITY TO CONTINUE WORKING BEYOND RETIREMENT AGE.

Projected shortages of skilled workers, the reliability and organizational commitment of the older worker, and the recently developed measures of competencies make it increasingly desirable for employers to reconsider old practices and stereotypes that result in a continuing pattern of increasingly early retirements. Restructuring production procedures, reassessing employee benefit plans, and opening up opportunities for job rotation and reassignments would help employers adapt to the changing character of the workforce.

VIII-B PENSIONS/SOCIAL SECURITY

OVERVIEW:

An extensive system of providing for the retirement income needs of America's older population has evolved over the years. This system is based upon the so-called "three legged stool," comprised of Social Security, private pensions and individual savings, supplemented when practical by a fourth leg -- the opportunity to continue working.

The basic premise underlying national retirement income policy is that the nation should ensure its older population an adequate and secure retirement income which is reasonably related to one's pre-retirement standard of living.

The most serious problem the nation faces in achieving retirement income security is inflation. The problem is not only one concerning the level of inflation, but also the inability to predict that level. Inflation affects both short-term and long range planning for the funding and setting of adequate benefit levels for Social Security and private pensions. It also creates a serious disincentive for individual savings. Continued low productivity, coupled with high inflation, cannot support the expansion of private pensions and private savings or maintain Social

Security. Expansion of retirement benefits is feasible only in an economy with a rising level of general wealth generated by increases in productivity.

In general, the Dialogue participants agreed that our retirement income goals could best be accomplished by maintaining the Social Security system as a basic floor of protection for all workers, financed by payroll taxes shared equally by employers and employees. Individuals and their employers should be encouraged to build on top of this basic floor by providing incentives for the expansion of voluntary private pension plans and private savings. In addition, industry and government should explore innovative options to encourage older workers to continue in the workforce.

PENSIONS

RECOMMENDATION 1

THE EXISTING PRIVATE PENSION SYSTEM SHOULD BE STRENGTHENED BY GOVERNMENT POLICIES THAT ENCOURAGE INDIVIDUALS AND THEIR EMPLOYERS TO MAKE PROVISIONS FOR RETIREMENT INCOME BEYOND THE FLOOR OF PROTECTION FURNISHED BY SOCIAL SECURITY. HOWEVER, PRIVATE PLAN COVERAGE SHOULD NOT BE MANDATED.

The American system for retirement security is not simple, uniform and compulsory; it is, rather, complex, multi-faceted and voluntary. The strength of the system lies in its diversity. It is in fact, not a system but rather a series of specific reactions to different circumstances. Accordingly, proposals for improvement should be tailored to specific situations.

Any review of the private pension system in this country must take into consideration the short duration of its development. Private pensions in the United States date back only 35-40 years, and the evolution of this system in this relatively short period of time is remarkable, and its continued evolution and expansion should be encouraged.

Government policy should be designed to encourage further development of the voluntary system. The current regulatory environment discourages formulation of new plans, increases the incidence of plan terminations, and interferes with normal business practice. Specifically, needless reporting should be eliminated, prohibited transactions rules for qualified professional asset managers should be replaced by an "arms length" test, and expensive administrative requirements should be reduced.

The concept of a mandatory pension system -- proposed by the President's Commission on Pension Policy as the Minimum Universal Pension System (MUPS) -- is too costly to the federal budget and too great a burden on small business, and was not supported by the Dialogue's corporate participants. The 3% payroll tax recommended under MUPS would jeopardize the existence of many small marginal employers who, in the present economic environment, offer the greatest opportunities for growth and the creation of new jobs. A discussion on the idea of faster vesting under private plans led to the conclusion that accelerating program vesting would not deliver substantially more retirement security from large plans, rather it would only proliferate trivial benefit accounts or act as a severance pay program. It was noted that IRS already requires accelerated vesting in small plans.

RECOMMENDATION 2

INDIVIDUAL SAVINGS FOR RETIREMENT SHOULD BE ENCOURAGED

The problems of gaps in coverage and pension adequacy should be addressed through a federal tax system which encourages personal retirement savings.

Individual savings for retirement should be encouraged by extending the current tax treatment under Individual Retirement Accounts to employees covered by corporate pension plans. This would make both voluntary and mandatory employee contributions to retirement savings plans tax deductible. The decision by an existing corporate plan to receive employee contributions should be optional on the part of the employer.

Consideration should be given to the practice in other countries, such as West Germany, where the government matches an individual's retirement savings if they have remained untouched for a specified period of time. This government "bonus" plan would be restricted to lower paid employees (who have minimal deductibility and tax-free accumulation incentives) in order to provide them with a clear incentive to save.

SOCIAL SECURITY

RECOMMENDATION 1

THE FINANCIAL VIABILITY OF THE SOCIAL SECURITY SYSTEM MUST BE ENSURED.

RECOMMENDATION 2

SOCIAL SECURITY SHOULD BE A UNIVERSAL PAY-AS-YOU-GO SYSTEM, FINANCED SOLEY BY PAYROLL TAXES EQUALLY SHARED BETWEEN EMPLOYER AND EMPLOYEE. IT SHOULD REMAIN AN UN-FUNDED PROGRAM.

RECOMMENDATION 3

SOCIAL SECURITY SHOULD NOT BE FINANCED THROUGH GENERAL REVENUES. FUNDING TO MEET SHORT TERM AND LONG TERM NEED SHOULD INCLUDE CONSIDERATION OF CHANGES IN RETIREMENT AGE, COST OF LIVING INDEXING, THE RANGE OF CURRENT BENEFITS, AND THE POSSIBLE TAXABILITY OF SOCIAL SECURITY BENEFITS.

RECOMMENDATION 4

ALL PUBLIC SECTOR EMPLOYEES SHOULD BE COVERED BY SOCIAL SECURITY AS QUICKLY AS POSSIBLE, BEGINNING WITH FEDERAL EMPLOYEES (INCLUDING CONGRESS) FOLLOWED BY STATE AND LOCAL GOVERNMENTS, AS IS PRACTICAL.

RECOMMENDATION 5

INTER-FUND BORROWING IS ACCEPTABLE TO FINANCE ANTICIPATED SHORT-TERM DEFICITS.

RECOMMENDATION 6

THOSE WHO ARE WORKING SHOULD NOT COLLECT SOCIAL SECURITY BENEFITS. BECAUSE SOCIAL SECURITY IS DESIGNED TO PROVIDE INCOME TO RETIRED PEOPLE, THERE IS A CONTINUING NEED FOR A RETIREMENT EARNINGS TEST TO REDUCE BENEFITS AS ANNUAL EARNINGS EXCEED SPECIFIED LEVELS.

RECOMMENDATION 7

THE LEVEL OF BENEFITS PROVIDED SOCIAL SECURITY SHOULD CONTINUE TO BE ONLY A "FLOOR OF PROTECTION" AND SHOULD NOT BE EXPANDED. THE SYSTEM SHOULD BE REVIEWED TO DETERMINE WHICH OF THE BENEFITS IT PROVIDES HAVE STOOD THE TEST OF TIME AND SHOULD CONTINUE AND WHICH, IF ANY, SHOULD BE REDUCED OR EVEN ELIMINATED.

VIII-C HEALTH

OVERVIEW:

The resources required to meet the medical and health needs of an aging population in a society whose citizens expect highly technical, quality services, are of such profound dimension, that the participants in the Dialogue Panel and Workshops on Health, felt it necessary to identify areas for serious evaluation and study; a re-evaluation of the existing health delivery system for all ages, and a redefinition of Long Term Care, the area most likely to cause the greatest cost increases and the deepest social problems in the future.

The participants believe that the health care needs of the elderly population cannot be adequately met within the existing system of health care delivery and financing.

The tendency to add to programs does not solve the problem as today's needs are very different from those of yesterday, and cost constraint by placing limitations on reimbursement under government programs results largely in tax shifting rather than cost savings, so that the population, as a whole, still bears the burden.

Technologic advances in increasing the longevity of the population, in keeping chronically ill people alive longer and in swelling the ranks of those over 75 years of age, are a major success of this century, but they carry with them the spectre of cost burdens, particularly in the area of long-term care, that call for alternate solutions; new methods of care, and changing attitudes toward personal responsibility for one's own health maintenance.

Corporations have borne a major share of the cost of health care through financing of third party systems and their share of taxes for Medicare. Physicians and other providers are generally insulated from cost concerns by the third party payment system. Most workers are also sheltered from major concerns over health care costs through their coverage under comprehensive plans with all or much of the cost borne by the employer.

The participants fully recognize the severity of the problem of meeting health care needs of an aging population. They believe that neither National Health Insurance nor additions to or minor rearrangements of the existing delivery and financing system are likely to provide a viable solution. The participants also recognize the importance of participation in the solution by the Business Sector.

RECOMMENDATION 1

GOVERNMENT AND THE PRIVATE SECTOR SHOULD UNDERTAKE AN EXTENSIVE STUDY TO EXAMINE THE PROBLEMS OF AND INTERRELATIONSHIP BETWEEN THE TOTAL MEDICARE AND MEDICAID SYSTEMS. THE STUDY SHOULD LOOK FOR ALTERNATIVE SOLUTIONS (POSSIBLY INCLUDING SOME SIGNIFICANT RESTRUCTURING) WHICH WILL REMAIN VIABLE OVER THE LONG-TERM PERIOD.

Responsible participation by both labor and management, as well as other interested parties, should be utilized in conducting the study. It should examine, among other factors:

- The potential for cost containment through appropriate design of the programs.
- The linkage of health care problems with the problems of housing, nutrition, transportation and energy.
- Methods of reducing undue emphasis upon inpatient hospital care, such as greater utilization of home health care and hospices.
- The role of prevention (wellness, health promotion, health maintenance, health education) in lowering costs and improving the health of workers and the elderly.
- The problems of long-term care, how it should be provided and who should finance it.

RECOMMENDATION 2

UNDER EXISTING PROGRAMS FOR THE AGED, GOVERNMENT SHOULD INCREASE INCENTIVES FOR THE EXPANSION OF CARE BY HMOs* AND OTHER ALTERNATE DELIVERY SYSTEMS.

RECOMMENDATION 3

DEVELOPMENT OF INNOVATIVE AND EFFECTIVE MEANS OF SELF CARE BY THE AGED AND MUTUAL HELP AMONG THE AGED SHOULD BE ENCOURAGED BY BOTH GOVERNMENT AND CORPORATIONS. THERE IS CONSIDERABLE OPPORTUNITY FOR THE ELDERLY TO HELP PROVIDE HEALTH SERVICES TO THEIR PEERS. THEIR PARTICIPATION IN HEALTH CARE SYSTEMS WOULD HAVE THE ADDED BENEFIT OF ENHANCING THEIR FEELINGS OF USEFULNESS.

RECOMMENDATION 4

CORPORATIONS SHOULD BE ENCOURAGED TO DEVELOP WELLNESS PROGRAMS INCLUDING PROGRAMS WHICH WOULD BE APPLICABLE TO RETIRED EMPLOYEES.

RECOMMENDATION 5

CORPORATIONS SHOULD WORK WITH LABOR TO REDESIGN BENEFITS TO MEET THE SPECIFIC NEEDS OF THE AGED AND YOUNGER POPULATIONS AND PROVIDE APPROPRIATE INCENTIVES TO CONTAIN THE COSTS OF THE DELIVERY SYSTEM. BOTH MANAGEMENT AND LABOR MUST BE OPEN TO THE NEEDS TO RESTRUCTURE BENEFITS EVEN THOUGH IT MAY INVOLVE TRADEOFFS THROUGH BENEFIT SUBSTITUTIONS.

VIII-D THE MARKETPLACE

The Dialogue marketplace panel served as a workshop to develop recommendations. A background paper was circulated to all participants prior to the Dialogue. It is included in the appendix of this report.

The realistic appraisal of marketing data reported in the background paper, reveal the under-rated strength of the consumer power of the over-55 population. This Age Group accounts for a significantly greater share of consumer expenditures, in a wide variety of products and services, than do persons in younger age groups. The over-55 population numbers 46 million (one out of three U.S. consumer households), and represents over 400 billion dollars in annual income, 28% of all discretionary money, and over one-fourth of consumer purchases on the marketplace.

Although these figures indicate the potential economic power of this Age Group, they do not detract from the needs of those older persons who are either at the poverty level, or alarmingly close to it. Per capita income of households headed by a person in the 55-65 year age category, however, is the highest of any age group, and that of households with an age 65 or older head, is only $500 below the national norm.

*HMO - Health Maintenance Organization

Why has the over-55 population been ignored by marketers, except for those industries related to health care, and the more recent interest from the Travel and Banking industries? The answer seems to lie in the pervasive stereotypes of this age group which affect company attitudes and creates the impression that older consumers lack significant purchasing power, have limited consumer interests, and that they are all alike.

The Business Community needs to recognize that the over-55 population is comprised of persons of varied income levels, lifestyles, personal characteristics and consumer preferences. Successful marketing will depend upon careful segmentation of this vast consumer group and appropriate research strategies. Market studies of the needs of older persons may well lead to the development of products and services also beneficial to those in other age groups.

The marketing community, by continuing to focus on youth at the neglect of the older consumer, is not only failing to fulfill the real and essential needs of the over-55 population group, but it is also foregoing a major opportunity for its own economic expansion.

RECOMMENDATION 1

SENIOR MANAGEMENT SHOULD MAKE A CORPORATE COMMITMENT TO EDUCATE ALL LEVELS OF COMPANY PERSONNEL CONCERNED WITH CORPORATE MARKETING POLICY ABOUT THE TRUE CHARACTERISTICS OF OLDER CONSUMERS. THE NEEDS AND MARKETPLACE POTENTIAL OF OLDER CONSUMERS SHOULD BE APPRAISED IN FORMULATING MARKETING DECISIONS.

RECOMMENDATION 2

IN ORDER TO SUCCESSFULLY ADDRESS THE OLDER MARKET, SENIOR MANAGEMENT SHOULD COMMUNICATE ITS INTENT TO ALL MANAGEMENT LEVELS AND EMPOWER A CORPORATE TEAM TO DEVELOP MARKET STRATEGIES.

RECOMMENDATION 3

MARKETING STUDIES OF THE OVER-55 AGE GROUP SHOULD BE HIGHLY PERSONALIZED, UTILIZING QUALITATIVE RESEARCH TECHNIQUES SUCH AS FOCUS GROUPS THEY SHOULD BE CONDUCTED BY INDIVIDUALS SENSITIVE TO THE NEEDS OF OLDER PERSONS, AND SKILLED IN THE DESIGN OF MARKET RESEARCH STUDIES APPROPRIATE TO THIS POPULATION GROUP. OLDER PERSONS SHOULD BE ADEQUATELY REPRESENTED IN THE DESIGN OF SUCH STUDIES.

RECOMMENDATION 4

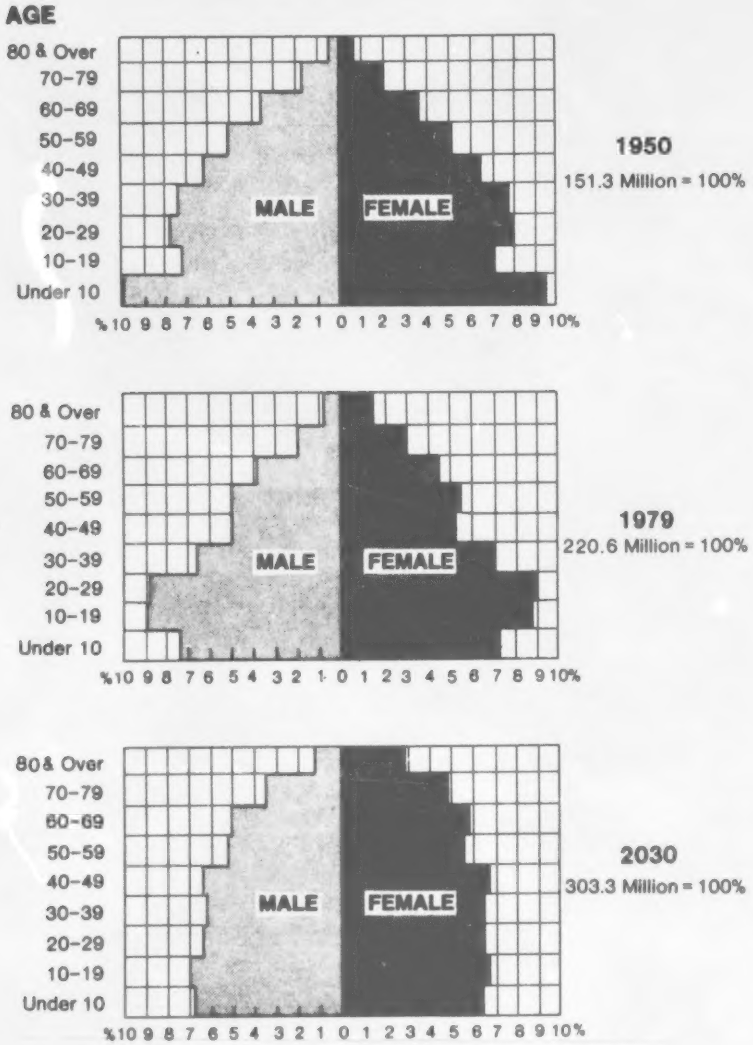
PRODUCT ADVERTISING SHOULD RECOGNIZE THE HETEROGENEITY OF THE OLDER POPULATION. OLDER PERSONS IN THE OVER-55 AGE GROUP SHOULD BE SHOWN WITH DIGNITY IN A VARIETY OF ROLES REFLECTIVE OF THEIR VARIED LIFESTYLES, CONSUMER INTERESTS AND ACTIVITIES IN EVERY DAY LIFE.

RECOMMENDATION 5

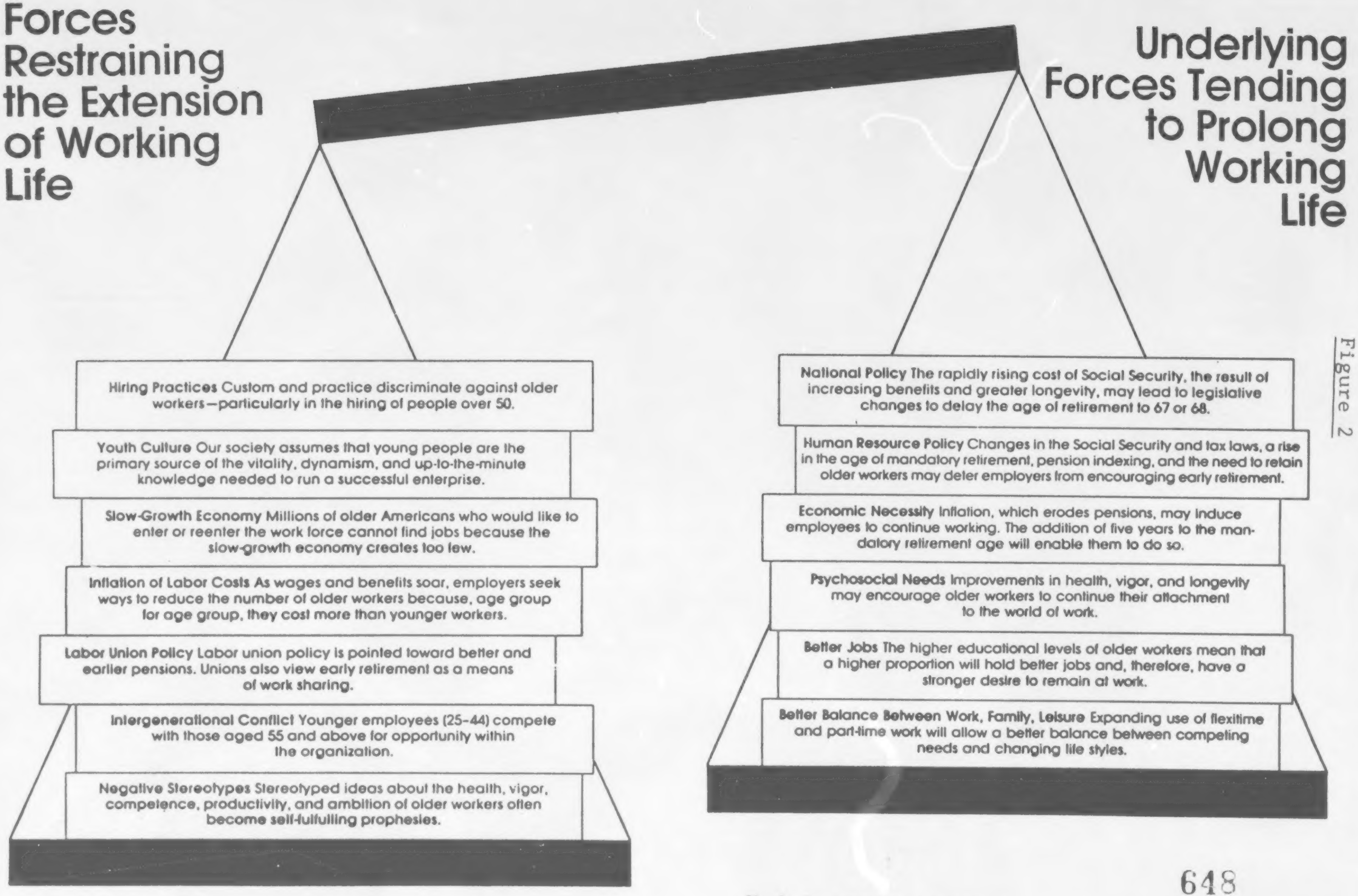
CORPORATE AFFAIRS DEPARTMENTS SHOULD MAKE A GREATER COMMITMENT TO SERVICING THE NEEDS OF THE OLDER POPULATION THROUGH A VARIETY OF CONSUMER EDUCATIONAL EFFORTS DIRECTED TO THE OLDER POPULATION AND GROUPS SERVING THIS POPULATION.

FIGURE 1.

Chart 1: Distribution of the U.S. Population, by Age and Sex, 1950, 1979, 2030



Source: U.S. Bureau of the Census, *Current Population Reports*, Series P-25, Nos. 311 (July 2, 1965), 704 (July, 1977), and 870 (January, 1980).



Forces Restraining the Extension of Working Life

Hiring Practices Custom and practice discriminate against older workers—particularly in the hiring of people over 50.

Youth Culture Our society assumes that young people are the primary source of the vitality, dynamism, and up-to-the-minute knowledge needed to run a successful enterprise.

Slow-Growth Economy Millions of older Americans who would like to enter or reenter the work force cannot find jobs because the slow-growth economy creates too few.

Inflation of Labor Costs As wages and benefits soar, employers seek ways to reduce the number of older workers because, age group for age group, they cost more than younger workers.

Labor Union Policy Labor union policy is pointed toward better and earlier pensions. Unions also view early retirement as a means of work sharing.

Intergenerational Conflict Younger employees (25–44) compete with those aged 55 and above for opportunity within the organization.

Negative Stereotypes Stereotyped ideas about the health, vigor, competence, productivity, and ambition of older workers often become self-fulfilling prophesies.

Underlying Forces Tending to Prolong Working Life

National Policy The rapidly rising cost of Social Security, the result of increasing benefits and greater longevity, may lead to legislative changes to delay the age of retirement to 67 or 68.

Human Resource Policy Changes in the Social Security and tax laws, a rise in the age of mandatory retirement, pension indexing, and the need to retain older workers may deter employers from encouraging early retirement.

Economic Necessity Inflation, which erodes pensions, may induce employees to continue working. The addition of five years to the mandatory retirement age will enable them to do so.

Psychosocial Needs Improvements in health, vigor, and longevity may encourage older workers to continue their attachment to the world of work.

Better Jobs The higher educational levels of older workers mean that a higher proportion will hold better jobs and, therefore, have a stronger desire to remain at work.

Better Balance Between Work, Family, Leisure Expanding use of flexitime and part-time work will allow a better balance between competing needs and changing life styles.

Figure 2

Work in America Institute

Figure 3

ESTIMATED SOCIAL SECURITY RETIREMENT PENSION AS A PERCENTAGE OF FINAL SALARY

RANGE LOWER PAID EMPLOYEE	MIDDLE MANAGER
SPAIN	90%
SWEDEN	73% - 37%
ITALY	66%
NETHERLANDS	66% - 29%
PORTUGAL	50%
BELGIUM	60% - 43%
UNITED KINGDOM	60% - 45%
SWITZERLAND	56% - 31%
GERMANY	55% - 40%
FRANCE	50% - 27%
DENMARK	45% - 22%

Source: International Pension Consultants GmbH

Figure 4

AGE OF RETIREMENT

Proportion of the working population of each country saying that the normal age of retirement in their profession is below age 60.

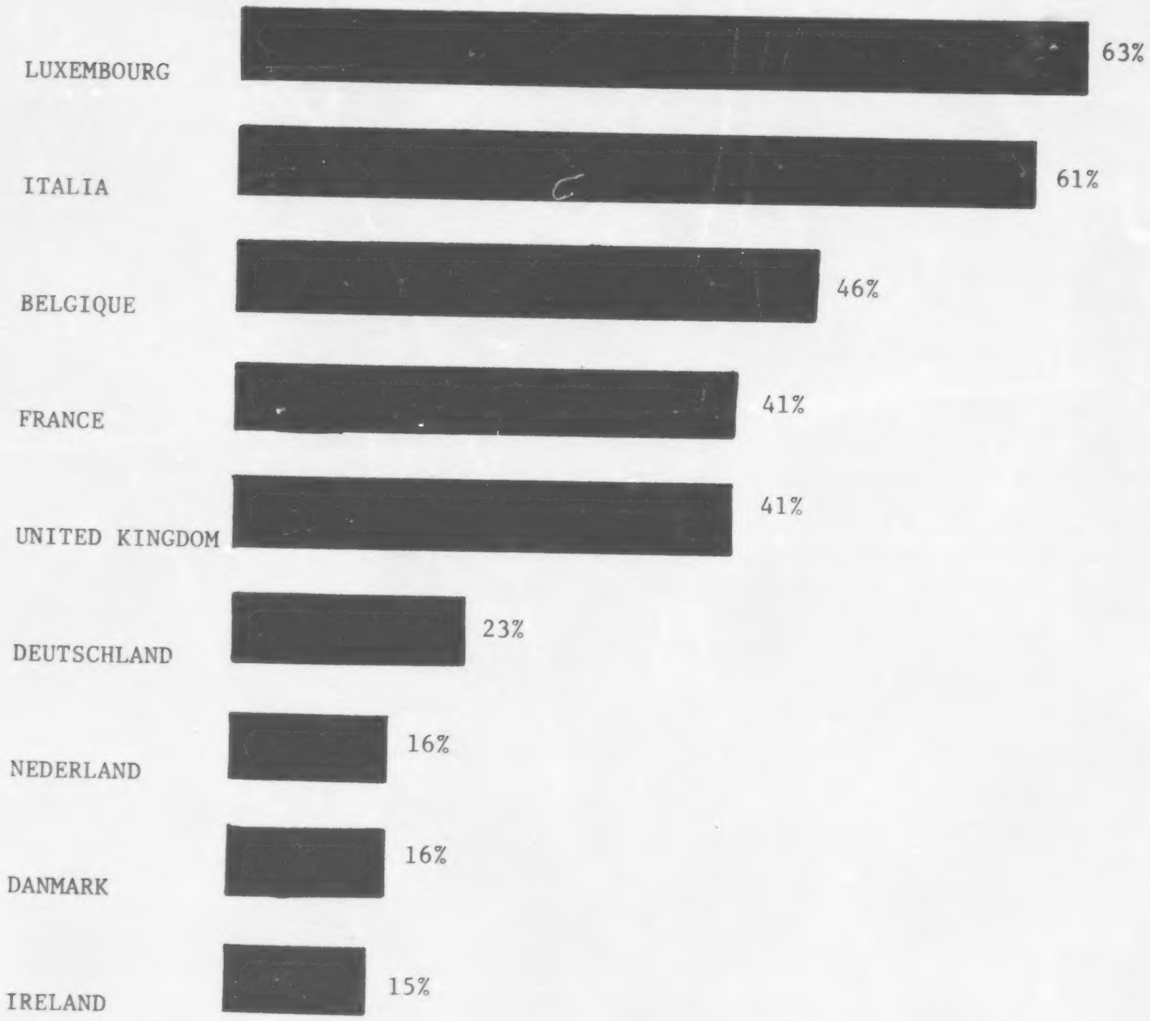
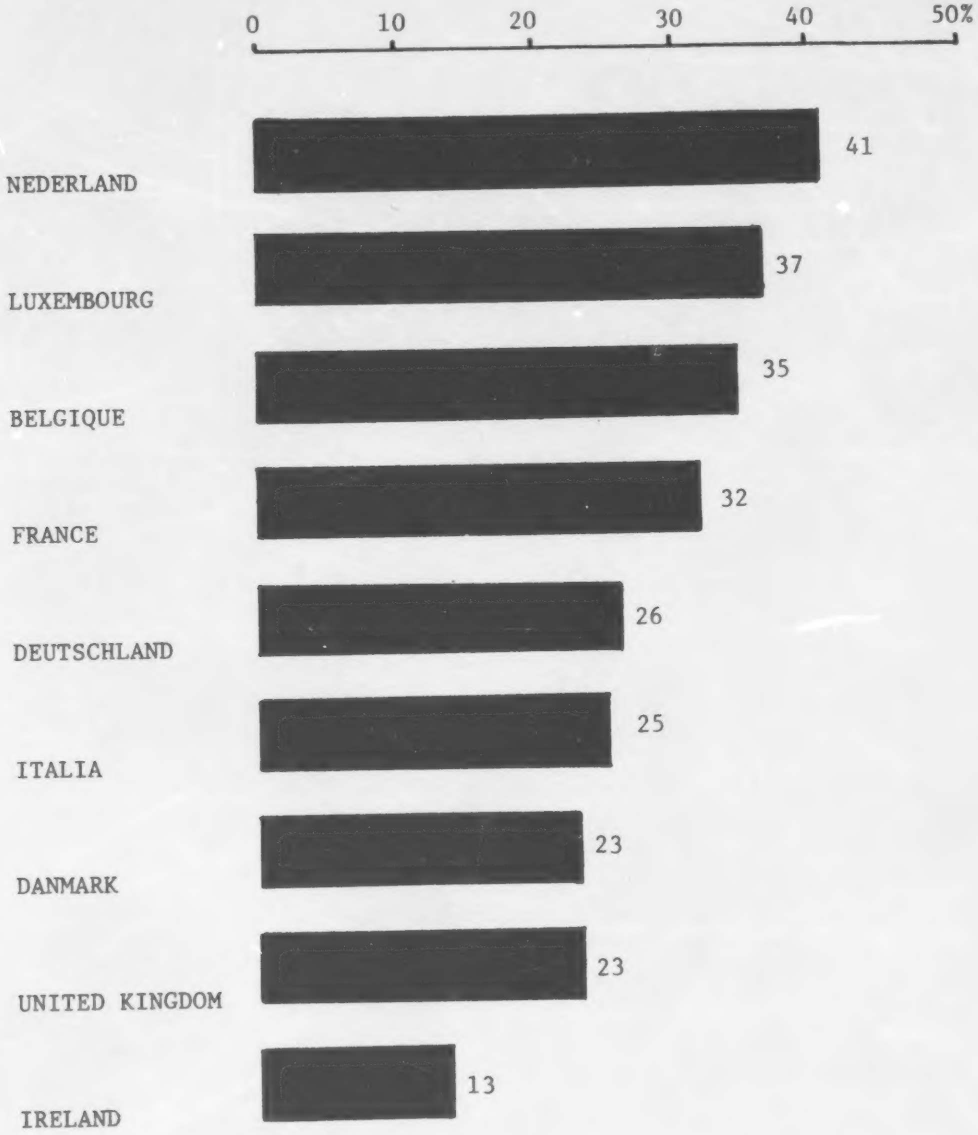


Figure 5

THE TEMPTATION TO RETIRE EARLY

Proportion of the working population in each country intending to stop working completely at retirement age and even before if possible. By country.



N.B. The average for the nine countries is 26%

Figure 6

TOTAL SOCIAL SECURITY CONTRIBUTIONS AS A PERCENTAGE OF SALARY

RANGE FOR LOWER PAID EMPLOYEE — MIDDLE MANAGER AS % OF SALARY

	EMPLOYER	EMPLOYEE	TOTAL
CATEGORY I:	HIGH EMPLOYER LOW EMPLOYEE CONTRIBUTIONS		
SWEDEN	31 - 26	Nil	31 - 26
SPAIN	31.9	5.5	37.4
ITALY	40.5 - 28	7.8 - 5	48.3 - 33
FRANCE	40 - 26	11 - 9	51 - 35
BELGIUM	24 - 20.7	9.7 - 7.3	33.7 - 28
PORTUGAL	23.5	10.5	34
CATEGORY II:	HIGH TOTAL CONTRIBUTIONS BUT MORE BALANCED BETWEEN EMPLOYER AND EMPLOYEE		
HOLLAND	24 - 18.5	20 - 15	44 - 33.8
GERMANY	17.5 - 11.5	16.5 - 10.8	34 - 22.3
CATEGORY III:	LOWER TOTAL CONTRIBUTIONS		
UNITED KINGDOM	13.7 - 13	6.7 - 6.4	20.4 - 19.4
SWITZERLAND	6.8	5.2	12
DENMARK	0.9 - 0.5	5 - 4.5	5.9 - 5

Source: International Pension Consultants GmbH

Figure 7

INCOME TAX PLUS COMBINED EMPLOYER AND EMPLOYEE SOCIAL SECURITY CONTRIBUTIONS AS A PERCENTAGE OF SALARY

RANGE LOWER PAID EMPLOYEE	MIDDLE MANAGER
SWEDEN	75% - 89%
PORTUGAL	41% - 60%
ITALY	58% - 56%
FRANCE	57% - 51%
NETHERLANDS	54% - 55%
DENMARK	35% - 51%
SPAIN	44% - 52%
GERMANY	44% - 43%
BELGIUM	44% - 45%
SWITZERLAND	18% - 28%
UNITED KINGDOM	34% - 41%

Source: International Pension Consultants GmbH

APPENDIX

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Dialogue Program

Funders and Co-Sponsors

Supporting National Business Groups, Planning Group and Staff

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Workshop Briefs:

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B. Social Security/Pensions
C. Health

Background Papers:

The Older Consumer
Government Mandated Programs

Endorsement Letter from The 1981 White House Conference on Aging

Press Release

THE NATIONAL DIALOGUE FOR THE BUSINESS SECTOR

PROGRAM

La Quinta, California

March 5-7, 1981

Co-Chairman:

Robert O. Anderson
Chairman of the Board
Atlantic Richfield Company
Los Angeles, California

Co-Chairman:

Marshall McDonald
Chairman of the Board and Chief Executive Officer
Florida Power and Light Company
Miami, Florida

THURSDAY - MARCH 5, 1981

3:00-6:30 p.m.	Registration
6:30-8:30 p.m.	Cocktails and Dinner
8:30-10:00 p.m.	Introductions Gwyneth G. Donchin, Dialogue Director Welcome Robert O. Anderson Dialogue Co-Chairman

FRIDAY - MARCH 6, 1981

Chairman: Marshall McDonald

8:30 a.m. - 12:30 p.m.	Plenary Session
8:30-9:00 a.m.	Aging: "What Is It All About? The Psychological and Biological Aspects of Aging as They Affect the Dynamics of the Corporation" Carl Eisdorfer, Ph.D., M.D. President, Montefiore Hospital and Medical Center, Bronx, New York
9:00-9:30 a.m.	Discussion
9:30-10:00 a.m.	"What Does Labor Expect From the Corporate Sector?" Howard Samuel, President, Industrial Union Department, AFL/CIO, Washington, D. C.

10:00-10:30 a.m.	Discussion
10:30-11:00 a.m.	Coffee Break
11:00-12:00 Noon	"What Does Government Expect From the Corporate Sector?" The Honorable Claude Pepper, Chairman Select Committee on Aging, U.S. House of Representatives, Washington, D. C.
12:00-12:30 p.m.	Discussion
12:30-2:00 p.m.	Plenary Luncheon Session "Policy Implications for the Corporation" Marshall McDonald Dialogue Co-Chairman
1:30-2:00 p.m.	Discussion
2:00-3:30 p.m.	Parallel Panel Debates

These debates are designed to surface a range of views and options. On each panel, four or five highly qualified presenters will give succinct five-minute position statements. These will be followed by a 30-minute debate among panelists with direction from the moderator. Interaction between the panelists and the participating executives will follow:

Panel One - Workforce/Productivity

What impact will the future workforce have on productivity? How can the Corporation strengthen its competitive position while responding to the conflicts and changing aspirations of workers, in view of:

.the changing composition and nature of the workforce;
.the change in retirement age and age discrimination legislation;
.employee expectations - training, education, health programming, life planning and retirement options.

Moderator:	Kenneth Smith, Ph.D. Dean, College of Business and Public Administration, University of Arizona Tucson, Arizona
Panelists:	Robert N.Beck, Director, Benefits & Personnel Services, International Business Machines Corporation, Armonk, New York David Bushnell, Ph.D., Director Center for Productivity, The American University, Washington, D. C.

	Donna Cohen, Ph.D., Associate Professor Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington
	Harold Sheppard, Ph.D., Associate Director, National Institute on Age, Work and Retirement. National Council on Aging, Former White House Counselor on Aging, Washington, D. C.
	Gus Tyler, Assistant to the President, International Ladies Garment Workers Union, New York, New York

Panel Two - Health

What options exist for the Corporation in responding to the rapidly escalating costs for financing health care programs in light of:

- .anticipated, substantial increases in health care requirements and costs attributable to an aging workforce;
- .the changing ratio of retirees to active employees.

Moderator:	Willis B. Goldbeck, Executive Director Washington Business Group on Health, Washington, D. C.
Panelists:	Carl Eisdorfer, Ph.D., M.D., Chairman, Department of Psychiatry and Behavioral Sciences, University of Washington, Washington, D. C.
	John Kittredge, Executive Vice President Prudential Insurance Company of America Newark, New Jersey
	James Vohs, Chairman and President, Kaiser Foundation Health Plan and Kaiser Foundation Hospitals,Oakland, California
	Richard Wardrop, General Manager Employee Benefits, Aluminum Company of America, Pittsburgh, Pennsylvania

Panel Three - Pensions and Social Security

What options exist for the Corporation in responding to the rapidly escalating costs of pensions, Social Security and other government mandated programs in light of:

- .deterioration of existing pension programs as a result of a continuing inflationary environment;
- .new pressures on the Federal Government to respond to the increased "welfare and security" expectations of the workforce.

Moderator:	Nicholas J. Mammana, Ph.D., Associate Dean, External Affairs, College of Business and Public Administration, University of Arizona, Tucson, Arizona
Panelists:	Harrison Givens, Jr., Senior Vice President, Equitable Life Assurance Society of the United States, New York, New York
	Woodrow Ginsburg, Director, Center for Community Change, Washington, D.C.
	Rita Ricardo-Campbell, Ph.D., Senior Fellow, Hoover Institution, Stanford University, Palo Alto, California
	Thomas C. Woodruff, Ph.D., Executive Director, President's Commission on Pension Policy, Washington, D. C.

Panel Four - The Marketplace

What impact will the 55+ population have on the marketplace?

.as consumers (needs, demands, characteristics and purchasing power);

.as owners (role of shareholders, influence on financial markets);

.as a political force with influence on legislation;

.as an influence on future research and development of new products design and adaptation, and services.

This panel will have a different format. A brief presentation will be made on the demographics and characteristics of the 55+ population. The myths about aging which affect market analysis will be explored. This presentation will be followed by questions posed by the moderator to the respondents.

Moderator:	Virginia Boyack, Ph.D., Vice President Life Planning and Educational Development, California Federal Savings and Loan Association, Los Angeles, California
Presenter:	Carole Allan, Ph.D., Allan and Associates Washington, D. C.
Respondents:	Meredith Fernstrom, Vice President, Consumer Affairs, American Express Company, New York, New York
	Rober T. Keane, Vice President of Public Affairs, ITT Continental Baking Company, Rye, New York
3:30-4:00 p.m.	Coffee Break
4:00-4:30 p.m.	Plenary Session
	Feedback from Panel Moderators

4:30-6:00 p.m. Dialogue Discussion: Who Will Share the Responsibility?

Discussion Leader: William Kieschnick, President
Atlantic Richfield Company, Los Angeles, California

Discussants: Carl Eisdorfer, Ph.D., M.D., President, Montefiore Hospital and Medical Center, Bronx, New York

Jack A. Meyer, Ph.D., Resident Fellow, American Enterprise Institute, Washington, D. C.

William Robbins, Director, Personnel, Imperial Chemical Industries-Europa Brussels, Belgium

Howard Samuel, President, Industrial Union Department, AFL/CIO, Washington, D.C.

William Seidman, Vice Chairman, Phelps-Dodge Corporation, New York, New York

8:00 p.m. Poolside Western Dinner

SATURDAY - MARCH 7, 1981

Chairman: Robert O. Anderson

7:45-9:00 a.m. Plenary Breakfast Session

"The Experience of the European Corporations"

William Robbins, Director, Personnel
Imperial Chemical Industries-Europa
Brussels, Belgium

9:00-9:30 a.m. Plenary Session

National Activities of the 1981 White House Conference on Aging

Policy Formulation by the 1981 White House Conference on Aging

Jarold Kieffer, Ph.D., Acting Director
1981 White House Conference on Aging
Washington, D. C.

The Tasks of the Workshops

Norman B. Solomon, Director, The EXECUTIVE BOARD, Phoenix, Arizona

9:30 a.m.-12:30 p.m. Parallel Workshops

Each workshop will have a chairman, one or more resource persons, a recorder and participating executives. The workshop participants will develop a set of reports on the following topics:

- Corporate expectations (or policy recommendations) for the 1981 White House Conference on Aging;
- Corporate expectations directed toward Labor;
- strategic alternatives for the Corporation;
- statement of Corporate concerns.

Workshop One - Health

Developing and Financing Programs Related to the Health Status of the Older Workforce and Older Population

Chairman: John Kittredge, Executive Vice President, Prudential Insurance Comapny of America, Newark, New Jersey

Workshop Brief: Willis Goldbeck, Director, Washington Business Group on Health, Washington, D.C.

Workshop Two - Social Security/Pensions

Developing and Financing Programs Concerned with Insuring Adequacy of Income in Retirement

Chairman: George Cowles, Senior Vice President, Bankers Trust, New York, New York

Workshop Brief: Harrison Givens, Jr., Senior Vice President, Equitable Life Assurance Society of the United States, New York

Workshop Three - Workforce/Productivity

Building and Maintaining a Productive Workforce

Chairman: Lucien Wulsin, Chairman, Baldwin Corporation, Denver, Colorado

Workshop Brief: David Bushnell, Ph.D., Director Center for Productivity, The American University, Washington, D. C.

12:30-2:30 p.m. Plenary Luncheon Session

Reports from the Workshop Chairmen

2:30 p.m. Adjournment

DIALOGUE PARTICIPANTS

CO-CHAIRMEN

Anderson, Robert O.
Chairman of the Board
Atlantic Richfield Company

McDonald, Marshall
Chairman of the Board and Chief Executive Office
Florida Power and Light Company

WORKSHOP CHAIRMEN

Cowles, George
Senior Vice President
Bankers Trust Company of New York

Kittredge, Jack
Executive Vice President
The Prudential Insurance Company of America

Wulsin, Lucien
Chairman of the Board
Baldwin Corporation

DISCUSSION LEADER

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President
Atlantic Richfield Company

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President
Allan and Associates

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Director, Benefits and Personnel Services
International Business Machines Corporation

Bushnell, Dr. David
Director, Center for Productivity
American University

Cohen, Dr. Donna
Associate Professor
Department of Psychiatry and Behavioral Sciences
University of Washington

Donchin, Gwyneth G.
Director
National Dialogue for the Business Sector-1981 White House Conference on Aging

Eisdorfer, Dr. Carl
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Fernstrom, Meredith
Vice President, Consumer Affairs
American Express Company

Ginsburg, Woodrow
Director
Center for Community Change

Givens, Harrison
Senior Vice President
Equitable Life Assurance Society

Keane, Robert B.
Vice President, Public Affairs
ITT Continental Baking Company

Kieffer, Dr. Jarold
Acting Director
1981 White House Conference on Aging

Meyer, Dr. Jack A.
Resident Fellow
American Enterprise Institute

Pepper, The Honorable Claude
Chairman
House Select Committee on Aging

Ricardo-Campbell, Dr. Rita
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Robbins, William H.
Director, Personnel
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Samuel, Howard
President
Industrial Union Department
AFL/CIO

Seidman, L. William
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Phelps Dodge Corporation

Sheppard, Dr. Harold
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National Council on Aging

Solomon, Norman B.
Director
The EXECUTIVE BOARD

Tyler, Gus
Assistant to the President
ILGWU

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Chairman, President and Chief Executive Officer
Kaiser Foundation Health Plan and Kaiser Foundation Hospital

Wardrop, Richard
Vice President and General Manager
Employees Benefits
ALCOA

Woodruff, Thomas
Executive Director
President's Commission on Pension Policy

MODERATORS

Boyack, Dr. Virginia
Vice President, Life Planning and Educational Development
California Federal Savings and Loan Association

Goldbeck, Willis
Executive Director
Washington Business Group on Health

McFadzean, William
President
McFadzean Associates

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the 1981
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Aging

Report of the Mini-Conference on the Urban Elderly

MCR-30

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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WHITE HOUSE MINI-CONFERENCE ON THE URBAN ELDERLY

A NATIONAL SYMPOSIUM ON THE URBAN ELDERLY: A PERSPECTIVE FOR THE 80'S

INTRODUCTION

The White House Mini-Conference on the Urban Elderly, A National Symposium on the Urban Elderly: A Perspective for the 80's, was convened by the Urban Elderly Coalition in Albuquerque, New Mexico, February, 1-3, 1981.

The Urban Elderly Coalition is a national aging organization established in 1972 for the purpose of coordinating a national effort to meet the problems confronting older Americans in our nation's cities. As the only national organization structured exclusively to address the problems of older persons living in our nation's urban areas, the UEC is able to provide a unique link among urban networks to impact on major problems facing our nation's elderly.

The UEC was assisted in conference development by national advisory groups which represented a broad spectrum of disciplines, national organizations, minority groups and others having an interest in urban aging issues.

Conference Focus and Theme

How will the growing elderly population affect America's cities? Conversely, how will projected demographic, technological and economic changes in urban areas affect older city dwellers? This two-fold question was the focus of this invitational conference which brought together representatives from a wide range of disciplines and diverse fields of practice.

The decade of the 70's has set the stage for continuing changes in American urban communities. During the 80's, these changes, both positive and negative, will profoundly affect the quality of life for all urban dwellers, and, will uniquely impact on the quality of life for the older urbanite. Within this perspective, the conference theme examined the older urban dweller in the context of:

- Demography -- how the changes in the composition of our older population may and/or should affect our life style.

- Systems and Structures -- an examination of the governmental/private, informal/formal, education/cultural, and banking/commerce systems and structures which impact on the older urbanite, in an increasingly complex society.

- Physical Environment -- an investigation of the city: mobility, accessibility, safety/crime, transportation.

- Social Environment -- consideration of urban living arrangements: neighborhoods; displacement/gentrification, condominium conversions, effects of relocation; home ownership, single room occupancy; growth of the older population in suburban areas.

- Quality of Life of the Older Person -- discussion of the impact of economics/inflation, involvement of family/support systems, role of the older person as voter/consumer.

Conference Participants

Criteria for selection of particpants was designed to ensure representation from among different disciplines, different interest groups and a wide geographic distribution. Invited participants represented the following groups: older persons; mayors; elected state, county and city officials; corporate and voluntary sectors; aging network spokespersons; gerontologists and experts in specialized fields. This participant group comprised those having greatest responsibility for setting policy and decision making affecting the urban elderly. Together they considered the impact of changes in urban settings and the growing older urban population.

The assembled group of 130 persons reflected one unique common characteristic -- shared responsibility for meeting the new challenges facing our nation's cities. Conference participant representation is presented in Addendum A. In all, 24 states and the District of Columbia were represented.

Conference Format

Commissioned issue papers were prepared on each of the five thematic topics. These papers were made available to conference participants in advance and, along with other background material, provided an operating framework for discussion. (Refer Addendum B)

·All persons age 65 or over are not homogeneous - age segments within the large group must be considered separately in accordance with their specific needs and characteristics. Cities likewise differ, depending on size, age, location and similar factors. However, there are general demographic trends worthy of attention:

- In 1900, 3 million people out of 76 million in the U.S. were 65 years of age or older. By mid-century, there were 12 million over that age, and by 1980 there were 25 million. By 2010 it is expected there will be 45 million elderly and 55 million by 2030 -- a 57% increase in just two decades. It is important to examine these numbers in terms of proportion to the total population, or the "share of the market" they comprise.
- Close to a quarter of our elderly population live near or below the poverty level.
- Though elderly Americans are healthier than ever before, many of those 75 and over need long-term health care.
- A majority (63%) of those 65 and over live in metropolitan areas. The elderly are more likely than younger citizens to be found in the central cities of metropolitan areas and in rural areas, particularly small towns. The central cities have experienced out-migration of families and those people with generally higher incomes.
- The largest numbers of the elderly are found in our nation's central cities - the same places where there are the fewest young families. Cities are losing revenue due to out-migration of people in the age groups having the highest incomes. That loss combined with the increases in the over 65 population, who tend to have lower incomes, means there is less total income to help pay for needed services. Cities are also operating under "budget caps" and inflation is eroding budgets resulting in forced service cuts.

Two approaches available to cities to deal with their dilemma are:

A more traditional and conservative approach having to do with focusing the governing powers or authority of the city on certain, primarily environmental, conditions known to be problematic for the elderly.

For the city to directly provide specialized human services for its senior citizens. (Mayor Boosalis described how Lincoln, Nebraska has gone beyond the governance approach to directly provide specialized aging services.)

During the initial plenary session, the commissioned authors presented highlights of their papers. Each presentation was followed by two commentators briefly addressing the same topic, but from a different perspective. The authors then presented summary comments and reactions. For example, the keynote address dealing with demographics, was presented by a mayor from a mid-western, cold-climate city with a population of 164,000. The commentators were (1) a mayor from a west coast, warm-climate city with a population of 79,000 and (2) a director of a state agency on aging in an eastern state whose previous experience had been as a city manager.

Following the presentations, three work group sessions were held on each of four topic areas (excluding demographics, since this issue served as foundation for all discussions). These work groups provided opportunity for broad discussion and formulation of recommendations. Each work group was led by a group facilitator, resource person and recorder. Conference participants attended specific work groups by assignment.

A unique and very important feature of the conference was the presence, throughout, of an "official conference observer/recorder". This individual, as well as "observing", received the written outcomes of each of the work groups which were then organized and synthesized for presentation to the full conference for final consideration and/or action during a closing plenary session.

As well as the above described presentations, leaders of four minority groups were invited to share the findings and recommendations of their respective White House Mini-Conferences. This additional background and resource information was absorbed into the deliberations of these proceedings.

ISSUE PAPER HIGHLIGHTS

For purpose of background information, highlights and key points of the five issue papers have been abstracted and are presented below. As with the full conference agenda, this material reflects only a summary of the authors' ideas, opinions and positions. It is recommended that the reader refer to the unabridged papers which are soon to be published.

The Aging of Our Urban Society, Helen G. Boosalis, Mayor, Lincoln, Nebraska.

As the chief elected city official, citizens look to the Mayor for improvements to the quality of their lives. In 1981, this means that mayors must realize that included among "citizens" are a high number of persons age 65 or over.

The Older Americans Act recognizes the importance of federal-state-local relationships, recognizes local initiative and encourages it. This very fundamental principle should be retained and advanced in any federal and state actions that require services to be delivered at a community level. In the case of elderly people, services must be delivered at the community level in order to overcome the physical limitations and travel cost limitations so frequently facing them.

Another fundamental principle supporting the concept of community-based services is the presence of the informal resources of volunteerism and neighboring. Public services cannot operate efficiently and effectively without these human resources being cultivated and utilized to the maximum extent possible.

Programs such as Old Age and Survivors Insurance (Social Security) and Supplemental Security Income (basic income maintenance programs) are matters of national economic impact and involve income transfers that can best be accomplished though uniform national mechanisms. Planning and public policy development must be accomplished for these programs at the federal level. Human services can only be delivered effectively at the community level.

Federal and State governments should recognize that local government is closest to the people. Appropriation of funds to to the local level should not carry specific categorical uses of the funds. Federal and State governments should raise the funds -- local governments should be accountable for the expenditure of them. Local governments must learn to cooperate. Cities and counties should share responsibilities and pool resources.

Urban Systems and Structures: Issues and Challenges, John E. O'Brien, Associate Professor of Sociology and Urban Studies, Portland State University, Portland, Oregon.

This issue paper addressed the following questions:

- What are the basic mechanisms by which the resources of scarce value are distributed to citizens and how well-served are the elderly by those mechanisms?
- What are the special features of urban life which pose particular challenges for the well-being of the elderly?
- What are some particular policy matters which relate to those supportive structures and systems, and what might be a sensible course of action by the Urban Elderly Coalition regarding each of those policy issues?

In discussion of these questions, it is recognized that the well being of people in any society is dependent upon (1) the abundance of life enhancing resources and, (2) the mechanisms for sharing these resources. In the U. S. this is accomplished through the labor market and the goods and services market. Since older persons are less able to receive remuneration for their labor so as to avail themselves of goods and services, a second mechanism of public administration is often the means of allocating resources to the elderly.

These two systems/structures need to be considered in terms of how public policy might impact the ability of the alternative mechanism of the market and the distributive mechanism of public administration to better serve the urban elderly. The elderly are not particularly well served by the market system which tends to favor the consumption patterns of younger cohorts. Employment is considered to be a source of monetary and informational power; since the elderly as a class are generally non-working they lose out on that source of power. Administrative systems have been unable to overcome three basic issues: (1) achieving an adequate blend of private, governmental, and individual involvement; (2) stabilizing their financing and control; and (3) assuring the needed forms of intergovernmental and inter-organizational relationships so that the services are adequately coordinated and delivered.

Three aspects of urban life are continuing to change in such a manner as to accelerate the already initial rate at which urban government is being challenged. They are: (1) the continuing increase in diversity of the people who inhabit urban places; (2) the increasing diversity and specialization of the forms of social organizations which dominate urban life and (3) the increasing centralization/nationalization/internationalization of the economic forces which support urban life.

The concept of the city as a "melting-pot" is changing. Urban policy should take into account the possibility that diversity among populational segments is a strong source of innovation and invention. Further, as people are compressed into dense urban living arrangements, they may cling to ethnic, cultural, religious, and other differences, and may choose to gain their share of resources through the emergence of civil leaders in the political arena. There is greater diversity among urbanites, including older urbanites.

Greater diversity among social organizations is growing also. This diversity impacts on all urban systems, making it more difficult to coordinate at all levels -- government and community service leadership units, human service organizations and voluntary associations.

The centralization, nationalization, and internationalization of economic forces has not resulted in the enhancement of urban life. Corporate leaders need to consider that actions taken at the corporate level have a direct impact upon urban dwellers, i.e., the shifting of employment opportunities and the resulting shift of dependency from the market system to the administration system.

Six specific policy issues are discussed:

- Strengthening the support base for urban systems through a levy of taxes on a regional basis rather than municipal or county basis, and redistributing the tax revenue in proportion to the number of individuals who "utilize" the city rather than in proportion to those who actually live there.

- Assuming the financial maintenance of the elderly by encouraging a longer working life (later retirement) for older people, and by finding a way to stabalize pension programs (private pensions, OASI, public employee pensions, etc.).

- Adoption of a nationally funded health care financing system.

- Institute a national value-added tax plan as a basis for generating revenue for local distribution to cities.

- In the delivery of social and nutritional services, incorporating these principles:

  1. In subsidizing service organizations, goverment action should be primarily aimed at supporting generic service units such as senior centers which can be used by all elderly persons regardless of means.

  2. When dealing with the ill, frail, or homebound, the involvement of government-operated agencies should be restricted to secondary functions such as service brokerage assistance by which to provide the elderly with information and assistance in packaging the supportive services which they need.

  3. The actual offering of direct services, particularly to the frail and needy, should be left up to private corporations (profit or not) on a fee basis, with government reimbursement for such services available when the personal means of individual clients are deficient.

- Systems Building. Human welfare and mental health services require the establishment and maintenance of service systems which by design are composed of organizational units with a broad range of operational styles and with professional staffs of differing persuasions about intervention. Without these, the types of service outputs will not parallel the range of diversity in client populations. To the extent that human service and mental health services are not organized in a manner which matches the life-world realities of potential clients, the services rendered will either not be used or not be effective.

Of special interest in this regard is the newly enacted Mental Health Systems Act which was passed by the Ninety-sixth Congress in October 1980. The Mental Health Systems Act (as with the Older American's Act) is specifically designed to facilitate the coordination of services while at the same time maintaining rather than reducing the variability in their organizational forms and functions.

The significance of this new act, focusing as it does on mental health systems rather than mental health centers (as did the act which it supersedes) harkens a new era of concern for maintenance of overarching systems within which diverse modes of services delivery and responsiveness to human variability in clientele can be maintained.

"Organizing for diversity" is clearly contrary to the typical mode of organization of services these days. This same approach should be adopted in most other service areas. But regardless of the extent to which it is desirable, the current mind set of municipal leaders and service professionals is that standardized, unitary service technology and organizational structure is really the best. This generates a barrier to improvements which must be overcome. In no area of life is diversity a more prominent characteristic than among the elderly. There is no other population segment which has a greater stake in seeing to the success of the "coordinated systems of diversified service forms" concept than the elderly. Furthermore, leaders from the "aging establishment" in most municipalities, already having a good deal of experience with the "coordinated service system" strategy, should exert substantial leadership in helping urban systems and structures more successfully accommodate to the challenges of the 1980's.

Aging in the Urban Physical Environment, Robert F. Wiseman, Ph.D., Senior Research Analyst, Office of Policy Development & Research, U.S. Department of HUD, and Associate Professor, Department of Geography, University of Kansas.

Older people are highly vulnerable to environmentally induced or exacerbated health problems, such as hypo and hyperthermia. Elders are generally more sensitive to environmental influences than other age groups. Our thinking of the physical environment often focuses on negative relationships between the invididual and the environment. Our concept of the physical environment is generally very narrow, often limited to natural elements such as weather, climate, and topography.

In its most general form, the environment can be defined as everything that lies beyond the individual -- the setting in which we live our lives. A useful way of viewing the environment is to organize the content of the environment along several dimensions or into several sets of related elements, e.g., physical, social, or cultural sets. The physical environment may be further divided into natural elements and those which are man made, sometimes refined to as the "built environment."

Each dimension of the environment is composed of discrete elements that have varying importance for the individual. The built environment, for example, consists of streets, sidewalks, homes and other buildings.

Beyond a consideration of the home environment, the choice of a residential location is often made with considerable attention to the content of the neighborhood and the spatial relationship of the neighborhood to the broader city or town environment. It is reasonable to assume that because a choice is involved in selecting location, reasonably good fit exists, between the individual and the involvement. A problems arises, however, because older people are residentially very stable compared to younger age groups. One-third of those over 64 have been living at the same address for more than a quarter century. This indicates that many elderly people selected a location within the environment at an earlier stage in life, when they were still employed and rearing families. With the passage of time and the transition from one stage of life to another, clearly their needs and preferences have changed, thus engendering environmental incongruence. For example, the importance attached to environmental elements such as schools and a social situation appropriate to rearing children, which may have weighted heavily in residential choice earlier in life, is reduced or eliminated in later life.

Even in the rare case in which the set of individual needs and preferences remains essentially unchanged, the passage of time results in perceived and often very real declines in most environmental dimensions. The built environment decays. The social fabric of the neighborhood changes such that many older people residing in inner-city locations now find themselves in environments with unstable populations and high crime rates. Shopping and entertainment opportunities once plentiful in older neighborhoods relocate to newer parts of the community.

The downtown portion of most urban environments, once the hub of employment, shopping, and recreation, is drained of its activities by suburban development. The decentralization of shopping opportunities in recent decades is a dramatic example of environmental changes to which the older person must respond. Unfortunately, many elders are suffering from mobility for merely sustaining life. Over time, then, both the content and context of the environment change and often begin to exceed the older person's competence level.

Environmental issues affecting urban elderly include:

- Air quality -- nearly one half of all people over 65 limit their activities because of chronic health conditions such as bronchitis, emphysema, and asthma. A large portion of chronic activity limitation stems from respiratory conditions which aggravated by air pollution and are the eighth leading cause of death among elders. More, and better air conditioning in homes, public buildings and transportation facilities away from sources of pollutants is also suggested.

- Noise levels -- a recent study revealed that excessive noise is a widely reported neighborhood environmental problem. As an environmental condition so bothersome that it made them want to move, suburban elders listed street noise. Central city elders ranked street noise second, just below crime. When street noise and airplane noise complaints were combined, the problem was nearly as often cited as crime. The problem is particularly acute when it interferes with normal sleep patterns. Possible solutions include: further regulation of noise producing activities, such as night time flight paths; factoring noise considerations into the design of new buildings, especially housing; paying greater attention to this factor in site planning; retrofitting present structures; and buffering site-specific sources of noise pollution.

- Home Ownership -- 73% of all people over age 64 own their own homes and the figure is projected to rise during the 80's. While rising utility costs and high taxes are a major problem for older home owners, home maintenance is a serious problem. High cost of repairs, physical inability to do self repairs, are factors contributing to research findings that the homes of elderly homeowners have more structural and systems defects than those of younger people.

- Home Renters -- there is a real shortage of suitable, available, affordable rental housing for older people. As well as high rental rates, many elderly have been forced to relocate because of rejuvenation, gentrification, and condo conversion.

- Mobility -- Most urban elders must depend on walking, public transportation, or friends and relatives for mobility within the urban environment. Nearly one-third of the elderly cite transportation as their most serious problem, ranking a close third behind income and health. Walking with packages is difficult and even more so when the distances to be traveled extend more than just a few blocks. Public transit does not exist in many small and medium sized cities. Where it does, routes are often inconvenient; stops and distant, unsafe and often devoid of shelters and benches; service is infrequent; and vehicles poorly designed and marked. Taxis are used infrequently because of their high costs.

- Safety and Security -- the elderly as a group are concerned about crime. While good data is not yet available to determine just how victimized the elderely are, they feel unsafe, resulting in self imposed restrictions of life style. When the elderly are attacked, they are more prone to serious physical and emotional damage.

The issue of personal safety within the environment has an additional aspect for pedestrian elders. A person over 60 years old is three times as likely to have a pedestrian accident as a younger adult. In 1978, more than 2,000 people over age 64 died in pedestrian accidents.

In summary there appears to be three general strategies that can be employed to improve the relationship between the older individual and his or her environment. These are: (1) increasing the person's level of resources; (2) improving the individual's environment; and (3) facilitating environmental interaction.

The Social Environment of the Urban Elderly: A View From the Street, Thomas O. Byerts, AIA, Director, University of Illinois Geronotology Center, and Associate Professor of Architecture, Chicago Circle Campus.

Social Environment can be defined as the real and perceived network of meaningful formal and informal relationship that exist within the context of an older person's life. Living arrangements, housing location, family structure, friendship network and neighborhood context play major roles in specifying the social environment. The perceived needs and responses provide an index to the quality of the social environment some of the major points made are as follows:

- While 63% of the elderly live in urban areas, the social environment from one city to another differs as it does from neighborhood to neighborhood within a single city.

- Most older urban people live the majority of their lives in the neighborhoods, and more specifically, in residential buildings.

- Social environment is really a product of family, friends, neighbors, service providers (public and private), and the bulk of people and objects that occupy a common space.

- It is the security and the availability of goods, services and the activities or common values that act as catalysts to bring people together to nurture one another.

- Close relationships of family members are an important part of the elderly's social environment. For many, no family relationships exist. This is particularly true of the single, frail elderly persons at risk.

- At the present time living alone is more typical of the white elderly population (47 percent), but 33 percent of the black live along, while 26 percent of the Spanish elderly live alone.

- Society still pays lip service to the vast untapped and often underserved human resource of older people. Society must care and take the time to improve programs and incentives to help older people help themselves, their peers and society as well as receive help from informal or formal service systems.

- The aging of the suburbs is a new phenomena that must be faced. Other dislocations due to gentrification of the older urban areas, condominium coversion of rental stock, rising property taxes and repair/maintenance costs are of concern.

- "Ageism" and "age related societies" are issues which will become contemporary as the demographics continue to change.

- Increased numbers of "old-old" (75 plus) lead to a larger share of resources being allocated to that more frail group, the old-old group includes a predominance of females.

- New social policy development needs to recognize the diversity among the elderly.

Some ideas to be considered are:

(1) Congregate Housing (Service-integrated group living).

(2) Expanded utilization of senior centers as a base for social and recreation activities, and service delivery.

(3) Integrated Health and Social Services.

(4) New family arrangements - foster home care, communal living, etc.

(5) Intergenerational programs - volunteer programs, etc.

(6) Review the accomplishments of the aging network to determine its ability to meet the needs of older people.

In conclusion, the challenge for the White House Conference on Aging is to shape policies and programs that can achieve significant gains for the urban elderly in a time of shrinking resources and severe economic constraints. It is time to engage the considerable latent capacity of older people and their families in molding a strong social environment for the aging and all citizens of the land.

Growing Older and Older in New York City, Roberta Spohn, Deputy Commissioner, New York City Department for the Aging.

The quality of life of an older person in an urban area is dramatically presented by Commissioner Spohn through detailed yet "typical" case studies of two elderly New York City residents. The experiences encountered by these two women and their families are replicated in all cities across the country.

In her paper, Commissioner Spohn made the following points:

- Cities and people have personalities -- they are not homogeneous.
- The differences of culture, ethics, language, and a persistence in exercising the rights of choice, life style, and the determiniation of priorities prohibit many urban elderly from being aware of and taking advantage of service delivery systems.
- These same differences make it difficult, if not impossible, for service systems to reach and serve each and every urban older person in the most appropriate way.
- In addition, the city and its neighborhoods are changing: condominium conversion of rental housing, increase in crime, inward and outward population migration patterns -- a preponderence of those with the least amount of income and greatest social needs remaining behind in the central city, along with an influx of "new" immigrant settlers, and etc.

Therefore, in consideration of these points, how then can the urban elderly maintain a satisfactory "quality of life"? Possibly, through the following:

- The White House Conference on Aging giving major consideration to the older, frail and minority aged renter who will be concentrated in the cities.

- Housing policies must ensure a growing supply of subsidized, well-designed rental housing for the aging and must include supported social services.

- Government strategies including favorable reimbursement rates must be devised to assist the minority community, including the Chinese and other Asiatic and the growing South American and Carribean Island communities; and to sponsor and operate institutional resources including nursing homes for their aged. While homecare must be made a univeral entitlement, the need for nursing homes will grow as more of the minority aged live into old age.

- The current system of multiple entitlements administered by numerous federal, state and local bureaucracies must be scrapped. Income supports must be adequate to permit the phasing out of the numerous benefits programs that supplement adequate income. Basic social services, particularly in-home services must be a universal entitlement under a nationally funded program.

The White House Conference on Aging must not divorce itself from the larger urban issues of the eighties. It must take an unequivocal position against any federal policy that contributes to "writing off" the older, industrialized cities of the midwest and northeastern sections of the country. A national strategy to assist business and individuals to move to the Sun Belt will guarantee the destruction of the homes and neighborhoods where the city's elderly live.

SUMMARY

At this conference the Urban Elderly Coalition hoped to bring together a cross section of people who have the shared responsibility for aging planning over the next ten years -- the people who will give direction, set policies, and make decisions for our nation's cities. Our hopes were realized.

The conference was structured to provide as much background information as possible, and to stimulate ideas and action. Beyond that, no effort was made to predispose the outcome of the conference.

Summary Remarks, Harold R. Johnson, M.S.W., Director, Institute of Gerontology, The University of Michigan, Ann Arbor, Michigan.

The synthesis of conference deliberations identified a number of recurring themes which provided a framework upon which conference recommendations were built. These issues are highlighted:

- The aging population is very diverse -- a point which must be kept foremost in mind in all deliberations during the next decade.
- Our contemporary society is extremely complex and in many ways has no comparison with any earlier era. Simplistic solutions to very complex problems in a very complex society will not work.
- Society is aging -- reflected in several significant ways: (1) in absolute numbers of older persons, (2) in the proportion of older persons in the total population, and (3) in the median age.
- The implications of an aging society must be recognized for both (1) the aged members of society themselves and (2) the effects of the increasing numbers of older persons on the aging society. For social institutions these effects will be dramatic, and perhaps traumatic, over the next decade.
- The population "implosion", or "urbanization", must be examined. Careful consideration must be given to the implications of mobility within urban areas which are continuing to expand.
- The contemporary technological explosion is having profound implication for our total society but particularly for the older members of our society. Caution must be applied so that older persons are not frozen out of high technology programs.

RECOMMENDATIONS

The deliberations of this conference culminated in a set of clear recommendations as distilled from the individual work group reports and conference process. Additionally, a number of issues were raised as grave concern to the conference participants and as being vital to the well being of older persons confronted with the problems of the metropolitan communities. Constraints of time, as well as the profound implications of these issues, precluded a consensus of opinion necessary to formulate specific recommendations.

On behalf of the participants of the White House Mini-Conference on the Urban Elderly, the Urban Elderly Coalition hereby submits for consideration by the 1981 National White House Conference on Aging the following recommendations, significant issues and resolution.

Recommendations

- Changes should be made in legislation, policies and regulations to provide local units of government, and/or regional authorities, the maximum degree of flexibility in designing and operating services for the elderly in their respective jurisdictions. However, in no instance should local or regional services be permitted to violate approved national minimum standards.

- An intensive and extensive public information campaign should be initiated, in every region of the nation, to increase the understanding of all age groups - including the old - about the process of aging and the circumstances of the elderly. By emphasizing the contributions, and potential contributions of the aged, the deleterious consequences of sterotypical attitudes that currently cripple many older Americans can be reversed.

- Institutions of government, private foundations and business, industrial organizations, and labor unions must be encouraged to sponsor basic and applied research in the field of gerontology. Only by expanding our knowledge base about the process of aging and the conditions of the elderly can we develop more effective and efficient supportive services.

- The WHCOA should adopt and promote a National Policy on Aging. This policy statement should be designed to provide a conceptual framework within which legislation, administrative policies, programs and procedures intended to improve the well-being of older Americans could be developed. The policy statement should include, but not be restricted to, the following points:

  (1) complete accessibility to a full range of health services, with a special emphasis on prevention and self care and accessibility to a continuum of social services;

  (2) expanded and improved housing programs to permit the aged adequate opportunities to make choices about their respective living arrangements;

  (3) develop a system of incentives that will encourage institutions of government and organizations in the private sector to design more and improved programs for the older members of our aging society;

  (4) expand opportunities for older adults to participate in programs designed to improve the quality of life for the aged and other population groups; and,

  (5) exapnd resources to meet the special needs of the aged who may have extraordinary difficulties due to minority status, poverty or health problems.

- Given the fact that there is currently a critical need for safe, sanitary, low cost rental housing for the urban elderly, it is strongly recommended that:

  (1) Increased allocations be made in the U. S. Department of Housing and Urban Development Lower-Income Rental Assistance Program (section 8, U. S. Housing Act of 1937 (P.L. 73-479) as added by Housing and Community Development Act of 1974 (P.L. 93-383) and the Direct Loans for Housing for the Elderly or Handicapped Program (section 202, Housing Act of 1959 (P.L. 86-372)).

  (2) Build on the above components, by granting subsidies to families in need of assistance, to keep older person in the family's home where feasible. Both financially and psychologically this would strengthen family ties and utilize the interaction and support through the different generations.

  (3) Take immediate steps to devise policies and procedures to encourage the private sector to build more housing appropriate for the aged and within their financial capabilities. Such a program might include tax incentives as well as more creative and flexible mortgage policies. Similarly, local units of government and non-profit sponsors should be encouraged and assisted to undertake a wide range of housing initiatives on behalf of the elderly. Housing programs sponsored by the public or private sectors should be planned to strengthen existing neighborhoods and communities and avoid the forced relocation of the aged and other population groups.

  (4) National and local policies of both the public and private sectors should be revised to provide the elderly the ability to buy and/or remain in their dwelling units through mechanisms such as reverse mortgages and section 8 type supports for owner occupied condominium units.

Significant Issues

- Age irrelevant society -- what does it mean? How would the elderly fare within such a society? Would their special needs be taken into consideration or would they be expected to fend for themselves in the common market place? Would they gain or lose as a constituency -- and does it matter?

- Block grants vs. categorical funding -- perhaps related to "age irrelevant society". Faced with increasing citizen needs and decreasing resources, can the state and local level of government be counted on to allocate block grant funds equitably and fairly to support aging programs and services? How much responsibility should the federal government assume over funds to states?

- Negative attitudes of clinicians and policy makers -- not enough emphasis upon the positive aspects of aging. Long term planning does not take into account new discovers in medicine, effects of the women's liberation movement, civil right's movement. These social and scientific changes will produce a different aging population within the next decade.

- Tax policies to encourage families to care for older relatives and assist in avoidance of institutionalization.

- Bureaucratization of human service agencies -- can services and programs be integrated and bureaucracy reduced so that older persons can understand and access it as necessary? As the present system grows, there is less sensitivity to those who do achieve access.

- Energy/inflation -- the elderly are particularly helpless against these two major societal problems. In developing fiscal and energy policy, the elderly must not be expected to sacrifice their ability to remain self-sufficient (e.g., depletion of life time savings) or to reduce their standard of living to an unacceptable status.

- Transportation -- planning needs to be done in context with other urban planning efforts: housing, development, location of services, access to health care, etc.

- Aging network -- unclear relationships with other state and local agencies still exist; tensions are still high.

- Use of volunteers -- more recognition of the value given and received through volunteerism. Greater support for senior volunteer programs. Recognition and utilization of the voluntary sector as an integral part of the service delivery system.

- Channeling of services -- systems are still fragmented. Access to services is not standard across the country. One stop centers -- or focal points -- seen as beneficial to consumers and providers.

- Intergovernmental relationships -- urban elderly are particularly affected by the degree to which governmental systems and structures do (or do not) cooperate. Disputes over control, responsibility and accountability are detremental to all citizens.

Resolution

Whereas, the Administration, in its effort to balance the federal budget, may consider cuts in human service programs;

Whereas, the programs that usually are cut first are the social services;

Whereas, if the cuts are in social services, the elderly and the poor living in our nation's cities are those most likely to suffer;

Whereas, the needs of the elderly and the poor are great;

Whereas, over 63% of the elderly now live in urban areas, which is increasing in proportion to the growing number of older persons;

Be it resolved that the Administration explore other areas by which to balance the budget so that the elderly and poor living in the urban areas of our country continue to receive needed services.

CONFERENCE PARTICIPANT REPRESENTATION

Mini-Conference participants represent a broad cross-section of persons concerned about and involved in urban-aging issues. The following listing identifies this range and diversity according to primary affiliation. It is recognized that many participants additionally represent multiple interests, organizations and/or affiliations, which enhance and enrich the deliberations and recommendations of this conference.

Aging Network	
Area Agency on Aging	4
State Unit on Aging	6
Administration on Aging	1
Federal Council on Aging	1
Aging Policy Center	1
White House Conference on Aging	3
Consumer Council	
Commission on Aging	6
Advisory Council	3
Health Care Council	1
Corporate Sector	
Business	12
Foundations	1
Elected Officials	
City	2
County	7
State	2
Mayor	3
Governor	1
Gerontologists/Academia	14
Government Agencies	
Local	6
State	1
Federal	1
City/County Aging Offices	20
National Organizations	11
Service Provider	
Service Agencies	17
Voluntary Organizations	5
Union Official	1

ADDENDUM A

ISSUE PAPERS: AUTHORS AND COMMENTATORS

The Aging in our Urban Society

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Lionel B. Cade
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the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on
Vision and Aging

MCR-31

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

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AGING & VISION

INSIGHTS:

A 1981 MINI WHITE HOUSE CONFERENCE
BETHESDA HOLIDAY INN, BETHESDA, MD.
JANUARY 11TH-13TH

RESEARCH
PROGRAM
POLICY

141 Attendees
21 States
All Self-Pay

Background Information on the Need

A variety of vision changes affect older people. These range from conditions affecting sensitivity to glare, difficulties in night driving, and daily living to severe and total blindness. A major theme of this conference was that no matter what the degree of vision impairment, there were many ways to live, work and function more effectively.

Estimates from Available Data Sources on the Need

There are many different types and degrees of vision loss and very different ways of measuring such loss. The following estimates reflect the most recent figures according to accepted definitions of different types of visual impairments. These figures were compiled by the American Foundation for the Blind, Social Research Dept. (1,2).

Legal Blindness

Legal blindness is defined according to central acuity of 20/200 or less (Snellen Chart Measure) in the better eye with the best correction, or a visual field which has narrowed to 20° or less.

According to the National Society to Prevent Blindness, in 1978, there were an estimated 498,000 legally blind persons, of whom 53% or 265,950 people were elderly (3). By this estimate, just over 1% of the nation's 25,000,000 older people were legally blind.

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ENDORSED BY THE 1981 WHITE HOUSE CONFERENCE ON AGING

The Conference

The 1981 Mini-White House Conference on Vision and Aging was convened at the request of the White House Conference on Aging by the American Foundation for the Blind and 15 co-sponsors.

The conference was organized and planned as a "working" meeting. A steering committee of co-sponsors reviewed proceedings from previously held national meetings on aging, blindness, low-vision and sensory function and developed eight working groups around the salient issues identified in previous meetings. The groups were:

1. Older workers with limited vision;
2. Expanding learning opportunities and media for vision impaired older people;
3. Developing an agenda of public education on vision and aging;
4. Advances in diagnosis and treatment;
5. Independence in community living and transportation;
6. Low Vision;
7. Models for rehabilitation and their application to blindness centers, senior centers and health care agencies and nursing homes;
8. Advanced technology in vision and aging.

The first sessions of the conference, a series or orienting lectures were presented by legislators, a panel of consumers, White House Conference Staff, and leaders in rehabilitation, medicine, low vision and aging services. These were followed by five-hour meetings of the eight working groups which developed descriptive lists of the issues of their topic area. (These are reported in longer Proceedings, available through the American Foundation for the Blind.)

On the third day of the conference, participants met to consolidate their recommendations under six areas and this is a summary of those consolidated reports. Each recommendation was individually read, commented upon by the full assembly, and voted upon. All of the recommendations were adopted with minor additions or wording changes as presented here. (Additional letters and comments are available in the longer Proceedings, as well as an analysis of related legislation.)

Recommendations were prepared by the participants in three areas of direct interest to consumers:

1. Public Education;
2. Rehabilitation and Treatment;
3. Low Vision and Public Policy

Recommendations in three additional areas are essential to using existing knowledge and experience more widely or effectively to implement the recommendations.

4. Professional Education and Professions;
5. Research;
6. Financing and Legislation.

Severe Visual Impairment

Severe visual impairment is defined as inability to see or to read ordinary newspaper print, even using one's glasses, if applicable. Statistics are based on interview responses rather than on actual measurements made by professionals.

According to the 1977 Health Interview Survey of the National Center for Health Statistics (NCHS), there were about 1,391,100 severely visually impaired persons in the noninstitutional population, of whom 71% or 990,000 persons were elderly (4). These severely visually impaired persons comprise about 4% of the elderly, non-institutionalized population.

Visual Impairments in Institutionalized (Nursing Home) Elderly Population

The 1977 National Nursing Home Survey of NCHS estimated that about 5% of all elderly people reside in nursing homes at any given time (5). In that study, it was also reported based on observations of nursing home staff, that about 3% of the residents were unable to see and another 26% were partially or severely visually impaired, giving a total of about 344,000 nursing home residents who were visually impaired in all.

Estimate of Serious Visual Impairment from All Studies

Keeping in mind that the Health Interview Survey and the Nursing Home Survey used different measures of visual loss, if we nevertheless add the figures from the two studies, we arrive at a rough estimate of about 1,334,000 seriously visually impaired elderly persons, of whom about 25% are in nursing homes.

Low Vision

A newer term, low vision, has been adopted to describe people who are partially sighted. The American Academy of Ophthalmology (8) defines low vision as "a state of imperfect vision which cannot be improved by medical or surgical means or by refraction." Genensky has estimated the size of the low vision population, taking into account both the estimates of "legal blindness" and of "severe visual impairment." Genensky concludes that the low vision or partially sighted population of the U.S. in 1977 was about 1,709,000 persons, of whom 48% or 824,000 were elderly (9).

Other Conditions

Most statistics on vision are based on the ability to read. No statistics have been collected on a national basis about the numbers of elderly who have difficulties with other conditions such as night vision, glare sensitivity or who need more light. Yet all of these descriptions repeatedly result from research on the vision needs of older people (10). It has been estimated that after age 75, one or more of these problems characterizes over three-fourths of all elderly people (10).

INDEX OF RECOMMENDATIONS: VISION AND AGING HIGHLIGHTS

(On the pages that follow, each of the recommendations is presented with corresponding background material. Roman numerals refer to topics (I-VI), letters to major recommendations (A-C) and numbers to specifications/sub-parts (1-10).)

I. PUBLIC EDUCATION
   A. Centralized Information Sources are Needed:
      1. For all consumers, a clearinghouse and a toll-free number;
      2. For all homebound blind, access to information;
      3. For professionals, a clearinghouse;
   B. People Need to Know About a Full Continuum of Vision and What They Can Expect At Any Level of Ability:
      1. "Functional Vision" should be emphasized (See Rec VB) because this refers to how people make use of vision;
      2. Vision needs to be considered in better relation to one's life-style;
   C. Media and Environments Could Be Made More Useful/Helpful to Older People With Vision Problems:
      1. Print legibility specifications are needed;
      2. Standards for physical environments and lighting are needed;
      3. Provisions should be made for print alternatives such as recorded materials and radio information;
      4. Barriers to wider use of print alternatives should be removed.

II. REHABILITATION AND TREATMENT
   A. Specific recommendations are made on six (6) pieces of existing legislation;
   B. A list of ten (10) basic components of community services for a full range of visually impaired older persons is recommended with strategies for development.

III. LOW VISION AND POLICY (Low Vision is defined on p. 2 of this report)
   A. Legislation and funding are recommended to provide low vision services to older people through public and private sectors;
   B. Educational recommendations are made to remove barriers to services;
   C. Research is advised specifically on low-vision and aging.

IV. PROFESSIONAL EDUCATION AND PROFESSIONS
   A. Funding, development, and provision of interdisciplinary curriculum are recommended;
   B. Coordination and dissemination of information from and to professionals are recommended (See Rec. I);
   C. Inservice and continuing education are recommended.

V. RESEARCH (See also: IIIC; IC; VIB.)
   A. It is imperative to coordinate research in vision and aging.
   B. Research should be performance (task) oriented (See Rec. III).("Functional" is defined in Rec IB1.)
   C. Social policy analyses and improved population data are needed in vision and aging.

VI. FINANCE AND LEGISLATION

A. Existing Legislation is reviewed with specific revisions and specifications.
   1. Medicare/Medicaid should include low vision services;
   2. Older Americans Act should cover identification of vision problems and fixing of responsibilities for services;
   3. Funding recommendations made for the Rehabilitation Act of 1973 to provide Independent Living Services for elderly blind and low vision service centers;
   4. Radio reading and print alternative audience expansion advised (See Rec. IC.);

B. Policy and Financing priorities are stipulated.
   1. For research funding, vision impairment and high technology are priority areas (see in conjunction with Rec V and IIIC).
   2. Research centers, combining older populations and researchers are advised (See also IIIC,and V.)

C. Specific recommendations are made for policy and financing of education on vision and aging with implications for Title VII of the Public Health Service Act, local schools, and education to and for people of all ages.

Other Highlights

For more information on these recommendations and the specific reports of the eight working groups, a separate set of Proceedings has been prepared and is available through the American Foundation for the Blind.

In conjunction with this Mini-Conference, a pre-conference meeting was held on topics of Research in Low Vision and Aging, sponsored by the American Foundation for the Blind in cooperation with staff from the National Eye Institute and the National Academy of Sciences. A report of that conference is available through the Social and Demographic Research Department, American Foundation for the Blind.

While tapes of all presentations/working groups were not made, National Public Radio prepared a broadcast around the conference and the Public Information Department of the American Foundation for the Blind has a one-hour tape (including the highlights of consumer Jessie Bain's presentation and background information on the conference) and several press releases.

Follow-up actions of the participants are listed following the consolidated recommendations.

I. PUBLIC EDUCATION ON VISION AND AGING

General Statement of Introduction

There are a number of public and private agencies providing information on services and problems in vision and aging. At the same time, there are a large number of older people of all income levels who have little or no understanding of their own visual problem, of the availability of service, nor of resources to meet their needs. This lack of awareness among older people, care givers and legislators has resulted in:

1. Underutilization of existing services;
2. Premature withdrawal from work or activities;
3. Unnecessary institutionalization;
4. Reduction in individual quality of life.

A system of public education is needed to address these concerns for consumers and for the community, as well as to advocate for the coordination of new and existing programs and services where needed.

IA. RECOMMENDATIONS ON PUBLIC EDUCATION THROUGH CENTRALIZED INFORMATION

To create more enlightened and sophisticated consumers and providers of services for the aging, visually impaired and otherwise, there needs to be better information available on both specific and general topics for both consumers and providers.

For Consumers

1. That Congress mandate the establishment of a comprehensive information and referral service in the Administration on Aging which is easily accessible via "800" telephone numbers, mail, and walk-in, to provide (after an informal interview) appropriate specific referrals and information about services available on a national,state, and local level, including public, private and voluntary resources.

   Actions Recommended

   a. That staff be adequately trained to provide explicit referrals and information in the areas of aging, vision, rehabilitation, vocational guidance, education and health care;

   b. That the service provide for ongoing gathering of current information from all sources.

2. That the Commissioner on Aging be encouraged to make grants to any public agency or private nonprofit organization or enter into contracts with any agency to develop or improve methods of coordinating all available social services for the homebound elderly blind and disabled as provided in the Commissioner's Discretionary Projects and Programs authority under the Older Americans Act, as amended.

IA. RECOMMENDATIONS ON PUBLIC EDUCATION THROUGH CENTRALIZED INFORMATION (continued)

For Providers

3. That a Central Clearing House of Information (e.g., Clearing House for Health Information and Health Promotion) be developed, using public health education models.

4. That a Coordinated Educational Network on vision, vision impairment and aging be developed.

   Actions Recommended

   That this network be developed by working with the various public and private agencies on services and resources available, service providers, program planners and managers and that such a network be accessible through schools, industry and community agencies.

IB. RECOMMENDATIONS ON PUBLIC EDUCATION REGARDING THE FULL RANGE OF VISION ABILITIES/CONDITIONS

Background

The public does not accurately understand the implications of "functional vision" and how such vision may be used in daily living. This is particularly true of the elderly (including those who are partially sighted, moderately or severely visually impaired) who have limited understanding of a continuum of vision and therefore of what their visual expectations might reasonably be. Such ignorance is a result of the lack of coordinated educational efforts which has raised problems for older people, families, care givers and legislators in terms of:

-Underutilization of existing visual services including resources available for people with low vision and the ultimate capacity to which vision and performance can be improved;

-Premature withdrawal from vision related activities;

-Unnecessary institutionalization;

-Diminution of the individual's quality of life.

Recommendations Regarding the Public Education on the Full Range of Vision Abilities/Conditions

For the Technical Committees of the White House Conference on Aging and the appropriations and authorizing Committees of Congress for Health Research

1. A coordinated effort needs to be undertaken at all levels, including governmental and private sectors, to develop a standard definition of vision as a functional entity and then to disseminate this information in a coordinated and sustained manner to the elderly consumer.

Actions Recommended

This definition should convey the concepts that:

a. Functional vision is that level of vision that enables the individual to perform those tasks essential to maintenance of his/her routine life-style; and

b. functional vision, for the individual, changes along a continuum, throughout the life cycle.

2. There should be educational programs on vision and aging integrated into all levels of learning (elementary, secondary, postsecondary and continuing educational programs).

3. A body of knowledge should be developed concerning vision and aging as it relates to visual function. This information should be made part of academic training at the appropriate levels of professional education (see Recommendations IV).

IC. RECOMMENDATIONS ON PUBLIC EDUCATION REGARDING EXTENDING MEDIA AND ENVIRONMENTS TO VISUALLY IMPAIRED OLDER PEOPLE

Background

Information and educational material pertaining to functional visual deficits is frequently disseminated in a format which diminishes its utility for the specific target audience.

Recommendations on Public Education Re: Extending Media to Visually Impaired Older People And Providing Environments More Conducive to Use

1. Printed Communications- Pertinent guidelines for visibility and intelligibility of communications materials should be developed by the National Bureau of Standards in conjunction with advisory groups of vision care professionals and consumers and these guidelines should be made available to the printing, publishing and other media industries.

2. Physical Environments- Functionally-based guidelines should be developed on the particular ways the physical environment (including lighting levels and types) should be modified to meet the needs of older people who are partially sighted or even moderately sensitive to conditions of glare or diminished light. These should be integrated into ANSI and other standards and their use should be urged in commercial buildings, residences and spaces or areas potentially usable by older people.

3. Print Alternatives: Radio and Recorded Matter- Government policy and support for services which provide alternatives to conventional printed matter should be encouraged with specific reference to radio information services for the blind, recorded matter, and legible alternatives to print.

4. Removal of Barriers to Wider Use of Print Alternatives- F.C.C. regulations, copyright laws and other legislation and policy should be reviewed with the objective of providing media in formats useable by people with a full range of vision and related physical impairments.

II. REHABILITATION AND TREATMENT ON VISION AND AGING

General Statement of Introduction

Funding resources are frequently rigid and uncoordinated. The legislative process fragments responsibility for the implementation of services: e.g., in the Older American's Act, where all monies are allocated to training service providers, there is limited emphasis on "self-help" concepts. Traditionally, rehabilitation and education emphasis has been placed on youth and/or vocationally-oriented consumers. There is a lack of development and awareness of private resources for funding.

IIA. RECOMMENDATIONS ON REHABILITATION AND TREATMENT RE: COORDINATION AND USE OF EXISTING PROGRAMS

Since older visually impaired Americans can benefit from services funded by different Federal Agencies, it is recommended that comprehensive and adequate funding across federal agencies be large enough in scope and flexible enough to facilitate the development and maintenance of high quality comprehensive service programs.

Actions Recommended

a. Fund Title VII, Part C of the Rehabilitation Act of 1973 as amended at a $10 million dollar level, irrespective of the status of funding of Title VII, Part A of this act.

b. Under section 504 of the Rehabilitation Act of 1973, incorporate the educational and employment needs of older persons, including the elderly visually impaired.

c. Expand the Vocational Education Act so that older persons including elderly visually impaired may take advantage of job retention opportunities and opportunities to develop new skills.

d. Expand the Senior Opportunities and Service Program under the Community Services Administration to guarantee the inclusion of elderly visually impaired and blind people.

e. Expand the Older Americans Act to include self-help programs for the elderly population, including the elderly visually impaired and blind.

f. Expand Title II and III of the Comprehensive Employment and Training Services Section 215, which can assist older workers in overcoming barriers to employment posed by changing physical characteristics associated with aging and Section 308 to conduct research on relationships between age and employment.

IIB. RECOMMENDATIONS ON REHABILITATION AND TREATMENT REGARDING COORDINATION OF SERVICES AT THE COMMUNITY LEVEL

Background

There is a need for increased comprehensive community services with coordination, shared training and communication among service agencies for the aging, agencies for the visually impaired, and for the blind. For a continuum of services to be implemented, it is necessary to determine the availability of needed services and the need for personnel.

Recommendations on Rehabilitation and Treatment Re: Coordination of Services at the Community Level

It is recommended that a comprehensive mandated system be implemented to establish the major program elements and manpower rerequirements necessary for a complete continuum of services to older visually impaired and blind Americans. This continuum would provide mobile and community-based interdisciplinary services without means tests and with consumer involvement. Components of a program of services for visually impaired older people should include but not be limited to:

1. Information and referral;
2. Outreach and transportation services;
3. Assessment, medical diagnosis and low vision services;
4. Counselling, social work and mental health services;
5. Rehabilitation teaching and orientation and mobility instruction;
6. Vocational and job retention services;
7. Development of self-help programs;
8. Home care services;
9. Adult education and recreation services;
10. Development of and access to technology, appliances and necessary consumer products.

Actions Recommended

1. Provide interagency task forces at the federal, state and local levels to establish the full continuum of services and to make these service components available through issuance of program policy statements.

These task forces should include representatives of Rehabilitation Services Administration-Services for the Blind, Administration on Aging, Social Security Administration, Community Services Administration, National Institute of Mental Health/Community Mental Health Services; Health Resources Administration; Long-Term Care and the private sector of non-profit programs and of other appropriate programs.

2. Encourage the interchange of direct services and consultant training for staff among vision/blind rehabilitation programs, aging service programs, and other appropriate programs to ensure the ease of entry for the visually impaired person into any service system.

III. LOW VISION AND POLICY

General Statement of Introduction

Visual impairment increases with age. **There are** lack of services, funding, communication and research in consumer and professional communities for addressing vision and age-related problems which result in costly dependency and institutionalization.

The vast majority of visually impaired individuals have useable vision. The public and professions in general are not aware of the distinctions between "blind" and "visual impairment," of the resources available to the visually impaired person and the ultimate capacity to which vision and performance can be improved. Finally, there is a gap between laboratory findings and their application to clinical problems and daily living.

Recommendations on Low Vision and Policy

IIIA. RECOMMENDATION ON SERVICE DELIVERY-FUNDING AND LEGISLATION IN LOW VISION

Legislation needs to be enacted to provide funding for low vision services (in private and public sectors) as a component of integrated health care. (See definition of low vision, first page.)

IIIB. RECOMMENDATION ON PUBLIC AND PROFESSIONAL EDUCATION IN LOW VISION

Specific actions are needed to effect change and reduce attitudinal, physical and fiscal barriers to low vision services through public professional education. This should include:

1. Development of a clearinghouse of information (See Rec. I.);
2. Development of models for service and service delivery;
3. Better utilization and coordination of national, community-based programs and organizations;
4. Funding from governmental and private sources to support public and professional education awareness programs.

Actions Recommended

The National Clearing House, described in several of these recommendations, should serve to disseminate information through mass media, curriculum development. continuing education and in-service training.

Health Systems Agencies, authorized under Title VII of the Public Health Service Act, should be targeted for the purposes outlined above.

IIIC. RECOMMENDATIONS ON RESEARCH AND TECHNOLOGY FOR LOW VISION AND POLICY (See also Rec. VI.)

Funding of low vision research should be encouraged which is specifically related to aging and which should be conducted in public and private sectors. Such research should be problem oriented and clinically based (see Rec. IB).

Actions Recommended

To encourage investigator initiated research (RO1) in the following areas:

1. Target epidemiological studies of high risk ethnic populations concerning visual impairments;
2. Low vision rehabilitation centers to develop a problem-solving approach to the functional vision difficulties created by visual impairment and to develop connections between laboratory research, clinical practice and rehabilitation services.
3. Psychophysical investigations of methods of vision evaluation which are related to function and performance should be endorsed and expanded.

IV. PROFESSIONAL EDUCATION AND PROFESSIONS

Background

Recognizing that current professional education in colleges and universities is inadequate to meet the needs of elderly with visual problems and the needs of those who work with or for such populations, steps need to be taken to devise and adopt curricula appropriate to the needs of older people with visual problems.

IVA. RECOMMENDATION ON CURRICULUM ON AGING AND VISUAL FUNCTION FOR PROFESSIONAL EDUCATION AND PROFESSIONS .

Within appropriate professional learning centers, fund, develop and implement curricula with an interdisciplinary approach as it relates to aging and visual functions.

IVB. RECOMMENDATION ON COORDINATION AND DISSEMINATION OF INFORMATION FROM AND TO PROFESSIONALS AND CONSUMERS

(See Recommendation I, similarly stated and to serve professional needs.)

IVC. RECOMMENDATIONS ON PROVIDING INSERVICE AND CONTINUING EDUCATION IN CLINICAL AND LONG-TERM CARE SETTINGS

Background

Continuing education is recognized as a critical need due to the ongoing research and developments in the fields of aging and visual impairments/rehabilitation.

Recommendations on Providing Inservice and Continuing Education in Clinical and Long-Term Care Settings

1. Inservice training should be encouraged and provided in clinical and long-term care settings;
2. Continuing education should be encouraged in the provision of up-to-date information to professionals in public and private practice/services.

Actions Recommended

An interdisciplinary approach should be taken to both the inservice and continuing education.

V. RESEARCH

VA. RECOMMENDATIONS REGARDING COORDINATION OF THE RESEARCH ENTERPRISES IN VISION AND AGING

Background

Research on vision and aging problems, particularly in the area of visual handicap, is fragmented. Although several federal agencies support such research, its priority within the individual agencies is generally low. We do not have a comprehensive national plan for coordinating the research efforts of federal agencies or a general consensus on research priorities. Researchers in various disciplines (biology, psychology, medicine, engineering and social sciences) are doing work relevant to problems of aging, vision and impairments, but there is insufficient interaction and exchange of information among them.

Recommendation Re: Coordination of the Research Enterprises

Coordination of the research enterprises in vision and aging is imperative.

Actions Recommended

1. Government agencies should develop a strategy for coordination of their research efforts and for development of a comprehensive national research agenda in this field. Opportunities should be explored for joint funding of meritorious research proposals that might otherwise fall between the cracks.

2. Mechanisms should be explored for fostering closer working relationships among the professions and scientific disciplines in research involving vision and aging (e.g., biologists, physiologists, clinicians, rehabilitation specialists, engineers and social scientists). Such mechanisms might include the development of centers which combine research and diagnosis with service delivery including a) integrative training programs for professionals, and b) use of existing journals and symposia (especially in basic vision science, gerontology, and engineering) to familiarize a broader population of professionals with the problems of vision and aging.

VB. RECOMMENDATIONS REGARDING THE NEED FOR RESEARCH TO BE PERFORMANCE (TASK) ORIENTED

Background

Further studies of the vision of older persons with intact visual systems are required and more appropriate tests of visual performance should be developed.

Low vision is common in the elderly and new and improved methods of diagnosis and treatment should be developed and their efficacy studied.

Low vision research and research training would be most effective if conducted in centers providing low vision services.

Recommendations Regarding the Need for Research to Be Performance or Task Oriented

Special attention must be given to supporting and funding of performance-oriented research to better identify and evaluate the vision characteristics of the elderly and to rectify or ameliorate functional disabilities.

VC. RECOMMENDATIONS REGARDING THE NEED FOR SOCIAL POLICY ANALYSIS AND IMPROVED POPULATION DATA ON VISION AND AGING

Background

There is inadequate knowledge of the population of concern, i.e., the vision status of older people as related to sociodemographic characteristics. Population-based studies on a national basis are also required to develop needs assessments and evaluations of programs and technologies.

Recommendations Regarding the Need for Social Policy Analysis and Improved Population Data on Vision and Aging

Population-based data collection is needed on a national scope in order to conduct policy relevant analyses such as:

1. needs assessments for services, research and technological development in aging and vision;
2. epidemiological studies;
3. cost-benefit analyses of services and cost control of service delivery;
4. evaluation studies of programs and technology;
5. better research on consumer protection and related consumer issues regarding vision care and prosthetics;
6. deployment strategies (getting devices into the hands of users and attendent problems).

VI. FINANCE AND LEGISLATION (Recommendations in this area are in part a summary of points made in the other five areas.)

VIA. RECOMMENDATIONS ON EXISTING LEGISLATION

1. Medicare and Medicaid amendments should be adopted to include low vision services as defined by the American Academy of Ophthalmology Task Force (refer to AAO definition, first page, this report).

2. The Older Americans Act should be amended such that:

   a. It is mandated that older Americans with vision problems be identified and provided with services;
   b. Coordinated mechanisms and a fixing of responsibilities be established at all levels and all authorizations of services for older persons with visual problems.

   Actions Recommended:

   (1) Monitor research and model projects at all levels in terms of these responsibilities for identification and service of problems with vision;

   (2) Assess the quality of services by using recognized non-governmental accrediting organizations.

   c. Encourage community based vision evaluation programs at the local level.

3. The Rehabilitation Act P.L. 95-602 should be funded and revised such that:

   a. Title VII should be funded up to authorization levels;
   b. Part C, Independent Living Services for Elderly Blind, should be separated from Part A of Title VII;
   c. The regulations implementing Section 305 should be revised to include low vision service centers.

4. Radio reading and print alternative services should be maintained and encouraged. Audiences should be enlarged by means of grant and funding support.

VIB. RECOMMENDATIONS REGARDING POLICY AND FINANCING OF RESEARCH IN VISION IMPAIRMENT AND RELATED HIGH TECHNOLOGY

1. Increased funding should be made available for research in the area of vision impairment, including high technology.

   Actions Recommended

   Such research should be made available through National Eye Institue, National Institue of Handicapped Research and through the private sector.

2. Research centers hould be established or enlarged to combine large client populations and researchers in multiple disciplines. (See also, Recommendations V.)

VIC. RECOMMENDATIONS REGARDING POLICY AND FINANCING OF EDUCATION ON VISION AND AGING/ FOR VISION AND AGING

1. Title VII of the Public Health Service Act should be utilized to encourage curriculum development concerning the visually impaired aged and related treatment and research.

2. At local and state levels, curriculum development should be encouraged concerning visual impairment, blindness and their prevention at all grade levels from elementary to high school levels. Such curriculum should cover the topic throughout the life cycle including old age.

3. Problems of the visually impaired aged should be made known to the public including older persons through continuing education. (See also: Recommendation Series I and V.)

SHORT TERM FOLLOW-UP

During the Conference several measures were taken to involve the participants in a number of responsibilities in carrying out these recommendations within their professional and personal abilities.

An ad hoc steering committee was established to disseminate these recommendations, and encourage state and regional level involvement in the activities necessary to implement them including those efforts related to the 1981 White House Conference on Aging. That Committee includes:

Alan Dinsmore, Legislative Office, American Foundation for the Blind, Washington, DC.
Ed LeMoine, American Council for the Blind, Washington, DC.
Stephanie Whyche, American Optometric Assn., Washington, DC.
John F. Nowell, M.D., American Academy of Ophthalmology, Falls Church, VA.
Lorraine G. Hiatt, Program Services/Aging, American Foundation for the Blind, New York City, NY.

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National Voluntary Organizations
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REFERENCES

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2. Kirchner, C. & Lowman, C. Sources of variation in the estimated prevalence of visual loss. Journal of Visual Impairment and Blindness, 1978, 72 (8), 329-333.

   For other statistics on the topic, see selected issues, Journal of Visual Impairment and Blindness, Statistical Briefs columns.

   For bibliographies on visual impairment, blindness, low vision and aging, contact American Foundation for the Blind.

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7. See the following articles for a discussion of the limitations of NCHS-NNHS and the problems of comparing its estimates with those of NCHS-HIS:

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   Kirchner, C. & Peterson, R. Blind and visually impaired nursing home residents: Some social characteristics and services received. Journal of Visual Impairment and Blindness, 1980, 74 (10), 401-403.

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GROUP LEADERS AND SPEAKERS

A full list of conference attendees is available from the American Foundation for the Blind. This list indicates individual who worked especially hard at the conference in leading their peers through the recommendation building process.

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Lou Bracknell
Herman Brotman
Jessie Bain
William Gallagher
Stephanie Whyche
Jerome Waldie
Mark Uslan
David W. Hartman
Eleanor Faye
Harry Walker
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Milton Jackson	Older Workers
Stephanie Whyche	Older Workers
Sandra Timmerman	Learning Opportunities
Robert Brieff	Learning Opportunities
Robert Rosenberg	Public Education
Edward LeMoyne	Public Education
Bella Jacobs	Public Education
Chas. Schepens	Diagnosis and Treatment
John Nowell	Diagnosis and Treatment
Stanley Brody	Community Living
Steve Massinari	Community Living
Al. Rosenbloom	Low Vision
Philip Shelton	Low Vision
Gerald Fonda	Low Vision
Randy Jose	Low Vision
Robert Winn	Rehabilitation
Stephen Ainley	Rehabilitation
Susan Phillips	Technology
Barbara Gastel	Technology
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the 1981
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Conference
on
Aging

Report of the Mini-Conference on Transportation for the Aging

MCR-32

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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NATIONAL MINI—CONFERENCE
ON

Transportation for the Aging

October 20 / 21 / 22, 1980
Sarasota, Florida

Jointly planned by
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INTRODUCTION

In view of the substantial changes anticipated for older Americans over the decade of the eighties, the 1981 White House Conference on Aging marks an important juncture and opportunity to consider these changes and the policy and program directions they imply for the next decade.

In every survey in which older people have been asked to voice their views of their needs for the future and the present, transportation and their mobility needs emerge as a key priority consideration -- as a matter of fact one of the top three priorities in all needs assessment of older Americans. In this context, it was considered essential to identify the major policy and program issues in transportation, and assure that they are given appropriate consideration by the National White House Conference on Aging in 1981.

Approach

In the context of the high priority given to transportation by older Americans and its "cross-cutting" role of integrating other program objectives and policies concerned with the elderly, two major objectives were designated for the mini-conference:

- Tap the views and thinking of a broad range of interests drawn from the transportation and gerontological communities as well as from the elderly.

- Identify issues and provide recommendations for 1981 White House Conference on Aging at the National, state, sub-state, regional, and local levels.

To achieve the objectives of obtaining the views of a broad range of interests and assure the transfer of these views to the 1981 White House Conference on Aging, an invitational conference was designed in which a wide range of concerned participants and elderly would be involved. Working with two Planning Committees especially organized for the mini-conference, a classification of seven groups of potential participants was developed covering the following interests:

Group 1: Elderly Consumers
Group 2: Transportation Service Providers (Public and Private)
Group 3: Aging Affiliated Organizations
Group 4: Related General Associations and Organizations
Group 5: Transportation Related Associations and Organizations
Group 6: Government Organizations
Group 7: Consultants and Other Individuals

Invitations were sent to representatives from all categories and 75 persons attended the mini-conference and participated in the workshops.

Each workshop had an assigned chairperson and leader who was responsible for recording comments and recommendations of the participants and a summary was prepared for presentation to the entire mini-conference at a plenary session. The workshops were structured around 17 major issue areas developed by the co-organizers and the Planning Committee. To assure proper representation, the Planning Committee was structured around the same groups from which the names of participants were drawn, and in fact, members of the Planning Committee were automatically included as invitees for the mini-conference. Within each of the 16 issue areas, a series of sub-issues were developed and these issues and sub-issues became the basis for 16 workshops from which emerged the findings and recommendations summarized in this Executive Summary.

Details on the workshop and the issues as well as related material will be available from the full report expected to be completed and available by April 1981. This Executive Summary is designed to transmit the key recommendations and comments to the 1981 White House Conference on Aging as quickly as possible.

MAJOR ISSUES AND RECOMMENDATIONS

I. Funding and Subsidies (Chairperson: Sally Ann Cooper)

The Workshop on Funding and Subsidies explored the issues relating to funding transportation services for older Americans. There was general agreement that a major problem was the difficulty in obtaining funds and the uncertainty from budget period to budget period. The Workshop participants felt that one means for dealing with the funding problem was through a more coordinated use of funds but that coordinated funding was hampered by the restrictions associated with each of the funding sources. It was observed that most projects are funded under the Urban Mass Transportation Act, the Older Americans Act, relevant sections of the Social Security Act, and to some extent (in rural areas) the Surface Transportation Act. Though there were other sources of funds, the latter were the most important and they each had different requirements and constraints on how their funds could be used. In this context, the Workshop felt that greater local flexibility in the use of funds would help with the state taking a more active role to help integrate this effort. The Workshop made the following recommendations.

1. There needs to be more local flexibility and fewer restrictions in the use of funds at the local level so that funds can be more easily pooled and coordinated around existing transportation programs, especially within any Department of Health and Human Services categorical program.

2. Similar flexibility should be provided in use of funds at the state level so that funds can be pooled in support of the program objectives determined at the local level.

3. Congress should appropriate funds sufficient to implement mandated programs on a continuing basis, and take into account inflationary cost increases as a minimum using a "maintenance of service" level as a guide.

4. Transportation brokerage should be used as one method for allocating funds among projects, and a degree of project continuity.

5. State governments should be permitted to use funds available under Section 16 (b) 2 of the Urban Mass Transportation Act so that they can be directed to either private non-profit or public transportation operators, providing such public operators assume responsibility for all transportation service provision in a given geographic area and meet specified service standards.

6. Depending on the particular need of a local area, both user-side subsidies and direct provider subsidies should have a place in the funding for local transportation.

7. Citizen advocates at the local level should work to convince local elected officials that transportation is a top priority.

8. Greater flexibility should be permitted in setting fares to be charged establishing a sliding scale for fares or in volunteered contributions in funding under the Older Americans Act.

9. Greater flexibility should be provided to local transportation providers in using funds for capital assistance or operating support.

II. Coordination (Chairperson: Joseph S. Revis)

Coordination of transportation services is an important issue, and was raised as a means of providing for more effective use of resources and improved services where resources are scarce (especially in rural areas.) While coordination was viewed by the Workshop as one way of stretching limited dollars, it was not viewed as a substitute for the need to expand existing funding sources. In general, many existing transportation projects experience insufficient capacity to meet the demands placed on them for providing services, and in such instances, the Workshop felt that increased funding rather than coordination should be the focus of attention. The following recommendations were offered.

1. The U.S. Department of Transportation and the U.S. Department of Health and Human Services should develop a more coordinated effort expanding from current coordination efforts. The U.S. Department of Transportation should take the active lead.

2. The coordination approach now in effect in California, Florida, and Iowa (where state-wide coordination is mandated), should be followed in other states and at the federal level.

3. Technical assistance for dealing with coordination problems should be made available by relevant agencies at the federal, state, and local levels.

4. Public transit agencies should be encouraged and an incentive program developed to increase their participation and role as an agent for local coordination.

5. To achieve a desirable level of coordination, there needs to be established a National policy on urban and rural passenger transportation.

6. The U.S. Congress was urged to get its own house in order and coordinate programs and activities among the multiple committees concerned with transportation.

7. A defined set of coordinating guidelines should be established for more centralized transportation funding to be used by all levels of government. The guidelines should include a review process as part of the coordination effort but the A-95 mechanism was not considered an appropriate channel for funding coordination.

8. The public transportation administration role of the Urban Mass Transportation Administration should encompass a broader base to include both rural and urban transportation services and policies.

9. Increased consumer advocacy for transportation for older people by local Area Agencies on Aging, state and national units on aging, and the network associated with the U.S. Department of Transportation.

10. An information, communication and technical assistance network should be developed that would bring together transit and specialized transportation providers. Such a network could be serviced by a field staff and a system of interns and trained individuals comprising specialists with expertise in transportation for the elderly.

11. Volunteers should be considered an essential part of the coordination effort, and the Internal Revenue Service should allow such volunteers the same deductions on their IRS returns as is currently permitted VISTA volunteers and as a general business expense.

12. A national program of technical assistance should be developed using volunteers, patterned after RSVP and using older retirees with skills in transportation able to provide help to local programs at no or minimal cost.

III. Accessibility (Chairperson: Eileen Koc)

The Workshop on Accessibility considered a range of philosophic, technical and financial issues related to public transit and special service systems serving older Americans. The Workshop noted that important questions relating to accessibility have emerged from recent U.S. Department of Transportation regulations promulgated relative to Section 504 of the Rehabilitation Act of 1973, not the least of which was the cost effectiveness of providing fully accessible public transit. In addition to cost, the Workshop raised the issue of social responsibility for providing transportation services; that is, what is the extent of society's responsibility for providing a range of transportation options for older Americans in order that they may avail themselves of the services and amenities available to others. The Workshop also raised the issue of who was responsible for providing transportation services: was it primarily the responsibility of the public transportation agency or a dual responsibility of public transit and social service agencies? In this context the following recommendations were made.

1. Transit operators and social service agencies have a dual transportation responsibility whether for door-to-bus stop or door-to-door services.

2. Transportation, either in support of home delivered services or in the form of assisted trips, should be provided in order to prevent or delay premature institutionalization of older persons.

3. The institutionalized elderly often have their mobility needs ignored. Trips should be provided to the elderly confined to institutions on the basis of the therapeutic value alone.

4. There should be a careful monitoring of the implementation of Section 504 regulations authorized by the U.S. Department of Transportation to insure that there is no net loss of mobility as "mainline" vehicles are made accessible to the elderly.

5. Although airports are required to be accessible, limousine services often are not. It is recommended that public airports develop some form of accessible service available as an option for disabled elderly and other disabled.

6. The staff of the national Architectural Barrier Board should be increased, and the Board given increased power to play a role in exercising waiver authity with regard to accessibility design for public transportation services.

7. User amenities for the blind, the hard of hearing, and the mentally impaired elderly should be required on all transportation facilities -- existing or new.

8. State Medicaid plans, under Title 19 of the Social Security Act, should be required to be more specific regarding the incorporation of transportation as part of their overall plan.

9. Elderly groups and individuals should be more directly involved in the planning and implementation of transit projects at the local level.

IV. Rural and Small Towns (Chairperson: Marion Campbell)

The Workshop felt that rural elderly have some special problems. The isolation of rural areas, the more limited availability of resources and (often) institutional support, makes the transportation problems of rural elderly more acute as compared to their counterparts in urban areas. Rural communities and facilities and services are often more widely dispersed (compared to urban areas) and roads are sometimes narrow and poorly paved, further hampering travel for the rural elderly. A lack of knowledge about existing transportation services seems to persist in rural areas and the rising cost of operating vehicles and a lack of adequate reimbursement have contributed to the decline in numbers of volunteers willing to transport the rural elderly. The Workshop also felt that the ethic of rugged individualism among many of the rural elderly affects their perception of transportation as an acceptance of "welfare". The following recommendations emerged.

1. The development of rural transportation systems should be given a high priority by state units on transportation, and state rural transportation services should be based upon plans developed by local service areas.

2. Federal grants for rural transportation should provide financial incentives for planning and coordination of service at the local level.

3. Planning a rural transportation service for the elderly should be a part of a broader framework for the economic development of a rural area on a county or multi-county basis.

4. A rural transportation plan for older persons should be the basis for implementing a larger plan for the development of a rural transportation system for the general public.

5. The findings of the Multistate Task Force on Billing and Accounting, underway now, should be disseminated to state units on transportation and on aging to help streamline reporting requirements for rural transportation providers.

6. Members of the aging network advocating the development of rural transportation services in each state should take a leading role in promoting coordination of transportation services for rural elderly at the local level.

7. The private sector should be involved in the development of rural transportation plans at the state and local levels.

8. Older workers should be placed in jobs related to the delivery of transportation services to rural elderly.

9. Information, innovative ideas, and technical advice about rural transportation should be coordinated nationally and disseminated to state and local service planners and providers, and to elected officials.

V. Minorities (Chairperson: Shannon Sorzanno)

The Workshop on Minorities considered the special problems of minorities in urban and rural areas and on reservations. They noted that as compared to non-minority elderly, minority aging persons: 1) were more economically disadvantaged; 2) had to work over a longer period of their life and a larger share were still working after 65; 3) lived in high crime areas and security problems with transit were more acute; 4) had more health-related disabilities inhibiting their normal ambulation; 5) had more difficulty in understanding or speaking English; 6) were less familiar with what transportation services were available; and 7) had the additional difficulty in making connection with transportation services outside the reservation (for those living on reservations). In the context of these special problems, the following recommendations were offered.

The Urban Minority Elderly

1. Bus routes and schedules should take into account the need for urban minority elderly to transfer to connecting routes.

2. Transit operators and neighborhood groups should take measures to assure the safety and security of inner city elderly riders.

3. The off-peak half fare policy should be expanded to allow for a sliding scale of lower fares at all hours for inner city elderly.

4. A driver sensitivity program should be instituted to teach drivers to communicate with non-English speaking elderly.

5. Bi-lingual drivers and staff should be employed by transportation systems serving non-English speaking populations.

6. A general information program on routes, schedules and other marketing material should be made available in languages appropriate to local ethnic populations.

7. Any potential cutbacks in service should be evaluated in terms of its impact on minority elderly before final action is taken.

8. Accessibility features required under Section 504 of the Rehabilitation Act should be supported in the interests of minority elderly.

9. To ensure equity for minority elderly, the U.S. Department of Transportation should pursue vigorous enforcement of Title VI of the Civil Rights Act.

10. All specialized transportation services should be required to interface with mainline transportation routes.

The Rural Minority Elderly

1. Transit providers and organized interest groups in rural areas should make a strong effort to reach out to minority elderly in their region.

2. A telephone referral service for transportation purposes should be established on a county or multi-county basis.

3. Specialized transportation providers should make every effort to see that minority elderly are served equitably.

4. Where appropriate in rural areas, specific social services should be brought to the home thus reducing or eliminating the need for transportation.

5. Reduction or elimination of matching funds required for financing some transportation services should be explored.

6. Where possible rural transportation services for the elderly should be funded with public funds.

7. Demonstrations of coordinated transportation services for the elderly should be encouraged under county or multi-county supervision (as appropriate).

The Elderly on Reservations

1. Transportation services to and from reservations should be managed by the Tribe populating that reservation but funded with public money.

2. In planning and developing services for the reservations, systems should be required to interface with mainline systems outside the reservation to the maximum extent feasible.

VI. Future Service Planning (Chairperson: John Falcocchio)

The Workshop on Future Service Planning considered the variety of demographic, social and economic changes anticipated for the elderly in the eighties. Changes identified which had important implications for future transportation service planning, included: an increased number of frail elderly and the number of people 75 years or older; an increasing share of elderly in suburban locations; increased part-time employment; an increase in the number of auto drivers aged 75 years and over and a much wider incidence of older women drivers; continued migration of elderly to the so-called Sun Belt; increase in the educational level of the elderly; and some redevelopment of the traditional central business districts for many cities. To deal with these issues, the following were recommended.

General

1. Extend the reduced fare program to include the peak hours of operation.

2. Provide for feeder service to fixed-route transit.

3. Provide access to mainline interstate transit services at reduced costs.

4. Provide personalized transportation services to the less mobile elderly.

5. Develop awareness by taxi-drivers of the special needs of the elderly who are also handicapped.

6. Develop driver education and driver improvement programs regarding age-related limitations, motor vehicle laws, defensive driving for novice drivers, and the like.

7. Improve vehicle design to accommodate older drivers.

8. Develop standard licensing procedures for elderly drivers.

Services and Their Location

1. Encourage decentralization of services to make them more accessible to the elderly.

2. Encourage the establishment of focal "checkpoints" to provide one-stop services for the elderly.

3. Provide mobile units for meals-on-wheels programs.

4. Coordinate the services for the homebound and isolated elderly.

Role of the Volunteer

1. Rewrite current regulations to encourage volunteer participation in the delivery of transportation services to the elderly.

2. Reimbursement for car mileage contributed by volunteers serving the aging should be permitted by IRS at the same level permitted for business purposes.

3. Provide funds for out-of-pocket expenses incurred in volunteer work, and permitting family members to be classified as volunteers.

4. Provide insurance protection for volunteers serving the aging.

5. Allow the use of "volunteer dollars" to match Federal dollars.

Role of Federal/State/Local Governments

1. Combine the resources of the public and private sectors in the delivery of transportation services.

2. Legislate insurance laws to encourage vanpools, carpools and similar pooling arrangements.

3. Review (transportation) provisions in the Older Americans Act to provide for flexibility in the use of money within a specific geographic area.

4. Encourage states to provide leadership in the provision of technical assistance for transportation services.

Role of the Elderly

1. Older persons should help educate elected officials at all levels regarding the importance of transportation services and put pressure on these officials to provide necessary transportation funds.

VII. Equipment and Facilities Design (Chairperson: Betty D. Revis)

The Workshop on Equipment and Facilities Design was concerned with the mobility limitations imposed by inadequate public transit vehicles and facility design. The participants of the Workshop felt that there was a considerable need for accessibility design improvements, and a range of vehicle comfort features were also needed for the elderly. The Workshop noted, that more information should be collected and distributed on vehicle performance, especially in terms of the ability to serve elderly clients. It was further observed that transit agencies should give greater consideration tc the use of small vehicles for serving the elderly. Rural operators were generally satisfied with vans despite a number of problems because they were easy to drive, were less costly and not too difficult to replace after 3 to 5 years and the safety record was good. Large public-transit vehicles had recently become more difficult for the elderly with the lack of handholds on lift-equipped buses or rear door "pushout" designs that needed considerable strength to open. The Workshop made the following recommendations.

1. The decision on vehicle specifications and selection should be left in the hands of the local operator subject to "performance" criteria.

2. Manufacturers of transit vehicles should be encouraged to produce a wider range of models.

3. More information on paratransit vehicle performance should be disseminated by the U.S. Department of Transportation.

4. The feasibility of transit using small attractive vehicles to appeal to the elderly should be tested and evaluated through demonstration projects.

5. Current federal standards for accessibility and performance characteristics of vehicles should not be permitted to damage small transit systems who may be serving by meeting local needs as well as possible within the available level of funding. The latter was especially true in small and rural communities.

6. The impact of accessibility requirements on the design of vehicles of all sizes should be evaluated in terms of the different requirements of disabled and non-disabled elderly persons.

VIII. Mobility Issues (Chairperson: Patricia Cass)

The Workshop on Mobiliiy considered questions such as the basic number of trips needed by the elderly, the purposes for which trips are made, the amount of income available for transportation, and the level of service available in both qualitative and quantitative terms. Greater coordination of services was needed, and it was felt that a federal mandate would encourage coordination, especially if accompanied with a similar mandate at the state level. In the context of these issues, the following recommendations were offered.

1. Transit and other transportation providers should coordinate their services with human service agencies in order to more effectively serve elderly with limited income.

2. Coordination of human services and public transportation services should be mandated by Federal and state governments.

3. Minimum standards for "special" transportation services should be established and the extraordinary costs for such standards paid for by Federal funds.

4. A single reporting form to satisfy the reporting requirements of all agencies should be developed for coordinated transportation providers.

5. A range of transportation options should be developed to meet the varying transportation needs of the physically and economically disadvantaged elderly. To the extent possible, physical and functional barriers which prevent or limit the use of public transit by the elderly should be identified and removed.

6. A national policy to facilitate car ownership by elderly should be developed taking into consideration problems of energy supply, availability of alternate transportation and capacity of the elderly to operate the vehicle with safety. In this context, driving safety regulations for older drivers should be developed.

IX. System Operations (Chairperson: Subhash Mundle)

A range of issues associated with the operation of transportation services were considered by this Workshop. Discussions included problems concerning vehicle and liability insurance, the availability of training and technical assistance for planning and system development, the need for better information and marketing systems, the use of volunteers, and the role of government at the Federal, state and local levels. The recommendations included the following.

1. States should take more legislative responsibility and formulate laws which address such matters as ridesharing and the liability of volunteers and drivers.

2. State insurance associations for elderly transportation should be developed, and training programs designed to reduce insurance rates should be designed.

3. Better information and dissemination systems should be provided by the U.S. Department of Transportation on sharing existing technical knowledge.

4. A model training program for elderly transportation systems should be initiated by federal agencies.

5. More use should be made of private resources, such as taxi companies in developing local marketing programs.

6. Incentives should be provided to attract more volunteers to work with transportation services for the elderly.

7. Elderly should be involved more directly in transportation development particularly in rural areas.

8. Systems of transportation for the elderly should be developed and designed to be more comprehensive in the scope of their services (i.e. trip purposes).

9. Regulations under Title III of the Older Americans Act should be modified to permit local agencies the option of charging fares for transportation services.

X. Research and Development (Chairperson: R.V. (Bud) Giagrande)

1. Given the substantial reliance on volunteer staffs in the provision of transportation services to the elderly especially in small urban and rural areas, it is recommended that research be directed towards establishing trends in the future availability of volunteers and what service impacts will occur if availability of volunteers changes (i.e. decreases as expected).

2. Research should be undertaken that will assist local planning units in developing special needs transportation during emergency and natural disaster situations.

3. Research should be initiated on design feasibility of a new multiple use vehicle. This vehicle should have features that will allow its joint use for pupil and special service transportation purposes.

4. An improved transportation research agenda should be developed setting up the process for bringing together public sector agencies, private for profit agencies and private non-profit agencies.

5. An increased research emphasis on assisting persons who have communication difficulties in the transportation environment should be set up for the visual/speech/hearing impaired to generate innovative methods of communication. These innovations should include visual aids for the hearing impaired, and audio, hand or textural aids for the visually impaired.

6. Establish a program of research utilization to develop a unified network of communication to increase utilization of completed research and experience from demonstrations to serve planners and service providers. A national clearinghouse of valuable information and data such as HEW's PROJECT SHARE, and UMTA's Centralized Accessibility Technology Transfer Program should be linked with other resources to provide timely and usable information on management of transportation systems serving the elderly and handicapped. Further, this network should have the ability to provide meaningful technical and management assistance.

XI. Energy and Inflation (Chairperson: Norman Paulhus)

Energy and inflation are linked in that they affect decisions on the level of service and whether cutbacks are required in transit services for the elderly. Among the range of issues considered were the impact of energy scarcity and inflation on service and strategies to reduce operating costs (such as bulk purchasing and pooling of supplies and equipment, consolidation of transportation services, and setting trip and service priorities).

The Workshop suggested that as regards the issues of energy and inflation and the role of government, three levels could be identified:

Federal: Exercise national oversight and take needed global initiative on economic policy and fuel allocation priorities.

State: Coordinate the use of available state resources, and monitor activities in the state.

Local: Set actual service standards and implement needed systems.

In addition, the following were recommended.

1. Demonstrations on new service approaches to energy conservation should be mounted, and information on workable approaches widely disseminated.

2. Volunteers or part-time employed elderly persons should be used by interested agencies to track energy-related information coming out of federal agencies.

3. Available funding resources for transportation should be increased to keep pace with inflation.

4. As an alternative to #3, funds for transportation programs should be reallocated within existing funding programs in order to respond to inflationary costs.

5. Volunteer assistance should be promoted by a system of reimbursement, in cash or in kind, and supported by training of volunteers with the aid of federal and state funds.

6. Collaboration on energy-related matters should be undertaken by local providers and service consumers in order to respond quickly to the changing energy situation.

XII. The Elderly and Transportation Service Advocacy (Chairperson: Bob Blancato)

The elderly are expected to participate in the planning of publicly supported transportation services, and current federal statutes on funding selected programs, mandate approval by Citizen Advisory Boards or at least require that public hearings be held on transportation plans. Citizen participation in the federal view is not intended to be a rubber stamp but a process of genuine involvement of citizen groups. Given the role of citizen participation in transportation planning, among the issues identified for consideration were how to expand such participation through training, technical assistance and information distribution, and how to encourage elderly citizens to take a part in the enforcement and monitoring of transportation systems serving the elderly. Recommendations of the Workshop included the following.

1. Citizen participation should be required at the policy making level as well as at the advisory and implementation levels of transportation programs.

2. Citizen Advisory Boards should receive training, particularly in technical areas in order to be able to effectively fulfill their role.

3. There should be closer scrutiny of the public hearing process to ensure broader participation by all segments of society.

4. State and local groups should conduct educational programs and community forums in small groups where elderly persons feel more comfortable in free discussion of the issues.

5. Legal services' attorney involvement should be increased in order to help elderly groups to develop and present their views at public hearings and in similar advocacy efforts.

6. Adequate transportation should be provided for elderly attending public hearings which should be held in locations accessible to the elderly.

7. Creative efforts should be employed to advise the community of public hearings.

8. Elderly groups should maintain close scrutiny and review of implementation of public hearing recommendations, in order to ascertain whether hearing recommendations are accepted, rejected or ignored.

9. Local and statewide elderly groups and Area Agencies on Aging should seek out technical expertise in their advocacy efforts in transportation for the elderly.

XIII. Personal Transportation and Pedestrianism (Chairperson: Darlene Winter)

Transportation in the form of trips by personal automobile (including auto trips by family, friends and neighbors) remain the most significant source of transportation for older Americans. Since the number of older Americans is increasing along with the number of licensed drivers (especially among women), it is safe to assume that there will be a corresponding increase of elderly drivers. At the same time, walking (pedestrianism) is also an important activity for older people, and in the light of these two considerations, the Workshop identified a number of key issue areas including assurance that older drivers will be given adequate consideration in driver liscensing and renewal procedures; the purchase of automobile insurance; the problems related to driver retraining; and issues of auto safety and the accident experience of older drivers. The Workshop's recommendations follow.

1. Licensure renewals should not be automatic but rather related to specific criteria which would have to be met and would not be age related.

2. Operator renewal procedures and criteria should be standardized among the states.

3. A professional/medical advisory group should be established to define basic screening criteria for drivers including such aspects as physical limitations, necessary road driving skills, knowledge of traffic laws, and the nature of the examination procedure itself.

4. Local examining boards should have latitude to review restrictive licenses governing special conditions.

5. Refresher driver education courses, taught in high schools, should be required as part of licensure renewal by all ages.

6. The legality and appropriateness of insurance providers automatically raising auto insurance premiums by reason of chronological age alone should be challenged.

7. Subsidization of transportation of frail elderly by family, friends and neighbors should be encouraged. In this context, the organization of innovative use of personal automobiles for a neighborhood transportation system should be encouraged.

8. Explore the feasibility of a system of voluntary relinquishment of private cars to non-profit local agencies who would assume total upkeep and maintenance of these vehicles in exchange for free transportation for the donor.

9. Developers of large retirement complexes funded by public monies should be required to include transportation services as part of their essential services for residents.

10. The use of units to bring grocery staples and other essential services to elderly residents at home should be encouraged and stimulated.

11. Barriers to safety created by engineering and design of traditional automobiles, roadways and roadway signs should be addressed, particularly as they relate to the elderly. In this connection, clearer and larger signs, larger "walk" lights, and more shelters and benches are especially relevant.

XIV. General Purpose Public Transportation (Chairperson: Ira Laster)

General purpose transportation covers basic transit services -- an important source of transportation for the elderly even though the level and quality of service may vary from community to community. Among the issues considered by this Workshop were the role of the "special efforts" regulations issues by UMTA; the impact of the U.S. Department of Transportation's regulations on Section 504; the role and impact of reduced fares policy and future needs and requirements; the use of UMTA Section 5 Formula Grant funds; and the role of citizen participation in transit service planning. A number of recommendations were proposed.

1. Transportation funds should be distributed in the form of block grants to local providers with freedom to identify local requirements and priorities.

2. The Section 16(b)(2) of the UMT Act requirement that vehicles funded under this Section be made available only to non-profit organizations should be modified to permit some state or local option to use these vehicles for publicly operated systems as well.

3. Reduced fares for elderly should be available at all hours of the operating schedule and not just the off-peak.

4. The "Special Efforts" requirements of Section 5 of the U.S. Department of Transportation regulations on behalf of the elderly and handicapped should continue over and above Section 504 compliance.

5. Elderly consumers must be represented on all local transportation technical advisory committees, and should be assisted in active participation.

6. Governments at all levels (federal, state and local) must assume more responsibility for subsidizing adequate public transportation systems.

7. Greater flexibility must be allowed to local governments in the use of transportation resources from state and federal sources.

8. States are urged to furnish appropriate technical assistance to local transportation providers or services when requested.

XV. Paratransit Services (Chairperson: David Lewis)

Most of the present transportation programs serving the elderly, it was noted by the Workshop, take the form of paratransit systems (these were defined by the Workshops as transportation services which do not use a conventional transit fixed route and schedule). A number of issues require exploration including the need for a national paratransit policy by the U.S. Department of Transportation; recognition of the relatively high cost of paratransit services reflecting higher quality of service; the importance of funds under Title III of the Older Americans Act for many paratransit services in communities throughout the country; the importance of and the need for a clearer (and therefore broader) definition of eligibility for paratransit services at the local level. The Workshop proposed 7 major recommendations.

1. Initially at least, paratransit systems should be aimed at those individuals most in need, with service priorities determined locally. In this context, in setting local priorities it should be recognized that elderly persons constitute but one of many groups to be considered in planning such services.

2. The heterogeneity of the elderly population should be recognized in assessing transportation needs which require varying levels of public support.

3. The current trends of diverting Title III funds under the Older Americans Act away from transportation services to other services should be halted, and a better balance between transportation and other services should be re-established.

4. Current Title III policy permitting only voluntary contributions should be re-written to permit greater flexibility for local transportation providers in order to strike a better balance between price and the quality of service acceptable to the local community and elderly.

5. Paratransit systems should be required to make full and practical use of all available community resources and facilities such as vehicles, management expertise and funding sources.

6. The role of private taxi services as part of paratransit systems should be encouraged, and technical assistance to local public agencies in negotiating service contracts with taxicab operators should be made available from state and federal authorities.

7. Additional costs incurred by taxi companies in furnishing shared ride services as part of paratransit plans should be recognized by state and federal funding but only in the context of marginal cost pricing.

XVI. Interagency Coordination at the Federal Level (Chairperson: Mike Albarelli)

The Workshop on Interagency Coordination at the federal level felt this was a critical area for encouraging the development of local transportation services. They noted that a large number of agencies are involved, especially at the Federal level, including: the U.S. Department of Transportation, Health and Human Services, Office of Management and Budget, Department of Housing and Urban Development and the Agriculture Department. Moreover there are several elements of coordination, such as service coordination, funding coordination, and policy/planning coordination. Among the central issues identified in the matter of Federal interagency coordination were: how to improve the interface between the two major Federal agencies concerned with transportation for the elderly, namely, the U.S. Department of Transportation and Health and Human Services; identification of a clearer role for the Office of Management and Budget in coordination developments; development of an interagency uniform accountability and reporting procedure; and how to integrate conflicting program requirements designed to meet diverse social objectives with coordination of funds and services. The Workshop's recommendations follow.

1. Coordinated transportation planning at the Federal level should integrate conventional transit needs with the social needs of the elderly, and not separate social service transport from transit systems. This should be true in both urban and rural contexts.

2. Formal Federal interdepartmental transportation coordination should be mandated by law as a means of stimulating greater amounts of coordination at the local level as well.

3. Responsibility for planning, staffing and funding Federal inter-departmental transportation coordination should be the responsibility of the U.S. Department of Transportation.

4. The functions of Federal coordination should include not only the coordination of categorical funding sources but also to allocate responsibility for service delivery and responsibility for determining payment for such services

5. The goals of the Federal coordination effort should be focused on participatory management process, that is, to assure a better management of Federal transportation resources, identify resource needs, and establish accountability at the Federal level for both state and local agencies involved.

6. The end result of the Federal interdepartmental transportation coordination efforts should be a clear and consistent statement of legislative intent allocating to the U.S. Department of Transportation the power to consolidate transportation resources and services at the Federal level.

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The 1981 White House Conference on Aging

Report of the Mini-Conference on

Simplifying Administrative Procedures and Regulations in Programs Affecting the Elderly

MCR-33

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LEGAL PROBLEMS
OF THE ELDERLY

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Commission on Legal Problems of the Elderly

January 30, 1981

SIMPLIFYING PROGRAM PROCEDURES FOR THE ELDERLY

A SYMPOSIUM REPORT AND RECOMMENDATIONS

SIMPLIFYING PROGRAM PROCEDURES
FOR THE ELDERLY:
A SYMPOSIUM REPORT AND RECOMMENDATIONS

The American Bar Association's Commission on Legal Problems of the Elderly sponsored a Simplification Symposium on September 27, 1980 as a White House Conference on Aging mini-conference.

One conferee, a legal services attorney, set the factual stage by describing the elderly, homebound individual's frustration at failing to obtain access to existing benefit programs, thereby facing the specter of confinement in either a nursing home or an institution. For instance, the lack of mobility may prevent an individual from obtaining the variety of services that are available only by filing a number of applications at multiple locations. Subsidized housing may be available, but the elderly person must go to the housing office to fill out a housing application. There may be homemaker services available, but the elderly individual must go to the location where the services are offered. There may be food stamps available, but that same elderly person may have to travel across town to the food stamp office to fill out yet another application.

What we offer in this report reflects a half-day symposium involving 28 of the best informed individuals in the field of aging (see appendix for list of conferees and their affiliations) and substantial staff research. This discussion was intended to explore the following:

a. Creation of a single application form for numerous human services programs;

b. Centralization of service entry points; and

c. Standardization of hearing and appeal procedures.

SINGLE APPLICATION FORM

Many elderly individuals have multiple needs and are eligible for more than one program at any given time.[1] Development of a single purpose intake form would make the whole process much easier for the elderly individuals and would relieve the government of the burden of repeatedly collecting data from a single person. It is very important to note that this would reduce both paperwork and administration costs.

The concept of a single application form for a number of human service benefit programs is not a novel one. In Wisconsin, a single purpose application is in use, collecting information necessary to determine eligibility for four programs: Food Stamps, Aid to Families with Dependent Children (AFDC), Medical Assistance, and Supplemental Security Income. The form, which reflects the present requirements of the four statutes and their regulations, is 36 pages in length. SPAARS Project officials (see below) hope to achieve significant reductions in both the length of the application form and in its processing time.[2]

Statutory Constraints

One method of reducing both the size and complexity of a single intake form is to consolidate and simplify the various forms presently used by human service programs, without violating federal and state laws and regulations. SPAARS (Single Purpose Application with an Automatic Referral Service) began in 1974 as an effort within the Mountain Plains Federal Regional Council to research and test the feasibility of adopting a single purpose application form of reasonable length for entry into the human service delivery system. The SPAARS Project sought to do this without violating the client's right to confidentiality.

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[1] Colorado SPAARS, Legal Constraints Study: A Conceptual Approach to Simplification of Human Service Programs (1977), at A-4.

[2] Ibid, at A-6.

In May of 1977, SPAARS published the Legal Constraints Study: A Conceptual Approach to the Simplification of Human Service Programs, identifying the legal 'constraints' to the development of a single purpose application.[3] A variation between programs was considered a 'constraint' if it necessitated (1) requesting additional information on an intake form, or (2) requesting information in a different form than the majority of programs. The goal of the legal constraints study was to identify program discrepancies and ascertain the work needed to achieve uniformity of eligibility terms among benefit programs.

The study documented variations in the categories most critical in determining eligibility (client identification, income, and resources) for Food Stamps, Supplemental Security Income, Aid to Families with Dependent Children, Title XX of the Social Security Act, Medicaid, Comprehensive Employment and Training Act (CETA), and Section 8 Low-Income Housing Assistance. A determination was then made as to which variations were purposeful in nature, i.e., involving legislative policy decisions, and which were merely the result of the regulation writing

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3. Ibid, at A-7.

process.[4] The study found that only 15% of the constraints were based upon statutory mandates reflecting substantive policy decisions.

SPAARS concluded that the development of a single purpose application is possible. It further recommended that uniform definitions of eligibility terms be devised and made available through a central agency, such as OMB, for use by agencies in drafting regulations for social service and income maintenance programs; and that interagency coordination in program design and means, as well as the writing of regulations, be achieved.

Development of Common Definitions

Pursuant to their recommendation that common eligibility terms be adopted by human service programs, SPAARS initiated the Intergovernmental Eligibility Simplification Project to investigate the feasibility of developing standard operating terms, definitions, and rules of eligibility.[5] The goal of this study was to: (1) identify differences in definitions of eligibility terms among human service programs; (2) recommend changes in laws and regulations for standardizing terms and definitions; and (3) assess the impact of the proposed changes on program participation rates and benefit levels.

The Project, begun in late 1978, compiled and analyzed the federal laws and regulations defining the terms 'income' and 'resources' as factors of eligibility in the programs studied by the SPAARS Legal

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[4] The study recognized the fact that variations in language may not be indicative of a variation in intent, that is, discrepancies may be due merely to the fact that multiple agencies are empowered to write regulations without any effort of coordination.

[5] Colorado SPAARS, Uniform Financial Measures for Use in Determining Client Eligibility: An Impact Analysis (1980).

Constraints Study (exclusive of Medicaid). The project developed uniform definitions for these financial need eligibility terms and examined the effects of using the newly composed definitions on participation rates and benefit levels of selected programs.

The Intergovernmental Eligibility Simplification Project concluded that it is feasible to standardize the terms governing the financial need requirements for client eligibility. By 'standardize' it is meant that the use of the same definition, valuation, and computation for each item of income and resource be applied in each of the programs so that client financial information would be treated in like manner among the service programs.

The goal of standardizing terms of eligibility is confined to language not significantly related to policy decisions as set forth by authorizing legislation. "Elderly" as a term of eligibility is an example of such a policy decision; e.g., generally speaking, individuals 62 years of age and older are entitled to Social Security benefits, while only those persons 65 years of age and older are eligible for Medicare. This distinction cannot be eliminated, and would not be included within standardization.[6]

Computerization

In addition to developing uniform terms and definitions for eligibility requirements, and selecting a single agency to devise and distribute these terms and definitions, the complexities and variations among programs that impede the development of a single application form may be ameliorated by the use of a computer system.

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[6] Symposium participants noted that much of the divergence in definitions from program to program reflects attempts by managers to respond to legitimate needs of current and potential program participants. A trade-off exists between simplifying and standardizing definitions on the one hand and administrative flexibility on the other. Benefits from such common definitions, however, far outweigh the loss in flexibility.

In order for a single form to contain the requirements of eligibility for a number of benefit programs, it necessarily becomes long and complex. A computer may be utilized to minimize the information the client is required to give on an initial intake form.

A computer may be programmed with program-specific eligibility requirements for each human benefit service. Client and intake worker would fill out an application form containing general inquiries about the client's age, health, family status, income, and resources. The computer would then be employed to make the differentiations as they exist among the various programs. For example, the client and intake worker would note whether the client owns a car; the computer would then be used to convert that information into its relevance to the food stamp program of the Medicaid program.

The computer may be employed whether or not common eligibility factors and terms are established. It may be used to differentiate between eligibility factors and terms as specified by each program's regulations, or it may be used merely to differentiate between program eligibility guidelines arrived at by way of the adopted, uniform eligibility language.

Trigger Questioning

As the computer system would minimize the number of questions necessarily contained in a single application form, so too would the use of "trigger" questioning.

As an alternative to asking a client a long list of questions about eligibility, prescribed by statutes and regulations, it may be possible to condense this highly detailed information into a few sensitive inquiries. Questions must be ordered in a way that an individual plainly ineligible for a specific program will not be forced to fill out an entire form before being apprised of the ineligibility.

For example, if a set age is a program requirement, the applicant's age should be asked immediately. If the individual is above or below the program's age specification, the form itself should direct the individual to discontinue filling out the application.

This method may lead to an eligibility determination at some acceptable ratio of accuracy, as compared with the list presently employed in the separate and program-specific applications.

Single Agency Supervision

SPAARS recommended that a single agency be authorized to devise uniform definitions of eligibility terms. The terms would then be used by the various agencies in drafting their own regulations. An extension of this recommendation would be to invest one agency with the responsibility of determining eligibility for all human service programs.

When the SPAARS Project was begun, its goal was to develop an operable single application of reasonable length that would not create confidentiality problems.[7] A single agency authorized to determine eligibility for all programs would eradicate the confidentiality issue necessarily confronted when a single application form is shared by a number of agencies.

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[7] SPAARS, Legal Constraints Study, ibid, at A-4.

This single eligibility agency would further the development of a single application form, whether or not it is used to develop uniform definitions and factors relating to eligibility terms. The single agency, familiar with the requirements of each human service program, could make the program-specific differentiations from an application form containing general client eligibility information.

CENTRALIZATION OF ENTRY POINT FOR SERVICES

> "In a nation where the old are growing older, the full floor of services must be mandated only for those who need it most; the frail elderly (75 plus) and those who have reached functional dependence before this age. These services encompass a single point of entry (emphasis added), one place to apply and to be guaranteed accessibility to all possible services...[8]

There is a great deal of discussion within the aging community on the issue of a single focal point for the planning and delivery of services to the elderly. The Subcommittee on Human Services of the Select Committee on Aging recommended in their report (96-226), published in May 1980, that both services and planning be decentralized.[9] They outline the following reasons for spreading services throughout a community:

1. Increases access for clients, especially those with reduced mobility;
2. Capitalizes on informal helping networks;

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[8] Future Directions for Aging Policy: A Human Services Model. (May 1980), at 96-226, III-IV.

[9] Ibid, at 59.

3. Is more responsive to clients' needs; and
4. Increases local autonomy.[10]

Congressman Pepper, on the other hand, has expressed a strong desire to have "single stop shopping for the elderly." The area agency on aging may be able to function as the information and referral service. The delivery of some social services may also be offered through a senior center, while others, such as housing, may not.

Centralization of Information

The model of a senior center, which not only disseminates information about benefit programs but also serves as a meeting place for elderly citizens to participate in the community and receive a nutritious meal, might function as the least obtrusive means of gaining information about what services are available to meet an individual's specific needs. This senior center would be located at the county/community level.

Centralizing Evaluation

It should be a goal to provide a focal point where there can be a comprehensive evaluation of the individual's needs, while the delivery of services to meet those needs should be decentralized. The evaluation aspect of the benefit system may be the only function amenable to centralization on the federal level. This form of centralization would not necessarily involve a central locale; it could involve a group of workers who go out into the community to determine what the elderly individual's condition is, what problems the individual is facing, which of the multiple services most address that individual's needs, and finally, how best to link the person with needed services. This form of centralization would require evaluation workers to deal with the various service agencies, thus eliminating the need for the elderly client to deal with each independently.

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[10] Ibid, at 59.

HEARINGS AND APPEALS

Elaborate and complicated hearing and appeal procedures present a barrier to the elderly individual's access to needed services. Not only is the older person forced to become familiar with the vast number of potential services, along with their attendant eligibility criteria, but the individual is further required to be versed in the procedural requirements associated with each program's hearing and appeal procedures.

Standardization

The numerous benefit programs available to the elderly vary considerably in terms of what, where, and how one files an appeal, or handles a hearing. Many lawyers are less inclined to do pro bono or reduced fee work for the elderly because appeals of rulings of ineligibility often entail wading through each program's procedures and regulations.

Standardization might be achieved with respect to the time period between an agency decision and the filing of an appeal, the number and type of documents filed, and/or the manner in which a hearing is conducted. Such standardization would encourage a broader group of attorneys to accept an older person's claim, while reducing the complexity and inaccessibility of the benefit system itself.

Access

As a practical matter, the individual who has the resources with which to finance an appeal has a better chance of success in obtaining the services to which he or she feels entitled. The hearings and appeals processes may often be made more accessible and equitable simply by paying reasonable attorneys' fees for accepting the elderly individual's claim. Not only would this provide an advocate for the needy individual, but also encourage the involvement of the organized bar in such matters. Any legislative or regulatory provision to expand reimbursement for legal representation would need, of course, to take into account the rules and policies relating to rendition of legal services to disadvantaged persons under the Legal Services Corporation Act and the Older Americans Act.

It should be noted that legislation has recently been created which provides for payment of counsel fees to individuals and small businesses in adversary administrative hearing and court proceedings against the government where it is determined that the government's position was not "substantially justified" (P.L.96-481, "Equal Access to Justice" Act, Title II). Although implementation has not yet commenced, this would seem to hold the promise of encouraging and facilitating elderly claimants' access to appellate recourse under government benefit programs.

Of equal importance, a strong capacity on the part of the Legal Services Corporation network to assist elderly claimants with assertion of hearing and appeals rights would also encourage meaningful access for senior citizens.

RECOMMENDATIONS

By sponsoring a Simplification Symposium, the ABA Commission on Legal Problems of the Elderly and its invited guests sought to advise the White House Conference on Aging. The conferees propose and the Commission concurs with the following recommendations to simplify and coordinate the maze of conflicting programs and regulations that presently confront the nation's elderly population.

(1) A single application form should be developed for the elderly for a number of benefit programs.

(2) To aid in the development of a single application form, common definitions should be set forth for areas that are not significantly related to policy considerations, as mandated by legislation or reasonably implied therefrom. This may be done by placing responsibility for the creation of these definitions with one agency or by giving a designated person of authority the responsibility for coordination.

(3) It should be a goal to provide a focal point where there can be a comprehensive evaluation of the individual's need, while the delivery of services to meet these needs should be decentralized. The variety of resources available to the elderly community, bounded by the scarcity of these resources, necessitates the utilization of centralized assessment criteria. The delivery of services must remain as local and diverse as the community service center or neighborhood church.

(4) The hearings and appeals procedures of the various benefit programs should be made as similar as possible. They might also be made more accessible by providing for government payment of reasonable attorneys' fees or expanded legal services capacity for representation of the elderly in such matters.

APPENDICES

A. Conferees

B. Federal Responsibility to the Elderly: Chart of Federal Programs Benefiting the Elderly

C. SPAARS Fact Sheet

D. SPAARS Executive Summary

E. SPAARS Table of Statutory and/or Regulatory Changes Needed to Standardize

SIMPLIFICATION SYMPOSIUM CONFEREES

Invited Guests	Affiliation
Craig Baab	ABA Government Relations Office, responsible for monitoring regulatory reform efforts
Bob Blancato	Staff director, Subcommittee on Human Services, House Select Committee on Aging; responsible for drafting Future Directions for Aging Policy: A Human Service Model
Sandy Boettcher	Hogan and Hartson; responsible for the firm's pro bono Food Stamp cases
Carlile Bolton-Smith	Retired, Social Security Administration's Office of Hearings and Appeals
Peter Conroy	Minority staff director, Subcommittee on Human Services, House Select Committee on Aging
Congressman Robert Drinan	Member, House Select Committee on Aging
Irwin Kirk	Chairman, SPAARS Committee, Department of Education, Colorado
Elliot Minceberg	ABA Section on Individual Rights and Responsibilities, Committee on Administrative Law
Bernard Nash	White House Conference staff; former executive director, American Association for Retired Persons, National Retired Teachers Association
Nell Ryan	Senate Special Committee on Aging
Robert Sermier	Department of Health and Human Services; Deputy Director for the President's Eligibility Simplification Project
Richard Swenson	Community Services Administration Regional Office, Denver; vice-chariman, SPAARS Committee
James Sykes	Member, Federal Council on Aging; member, Advisory Committee, White House Conference on Aging; chair, Public Policy Committee, National Council on the Aging; runs local aging program
Jerry Tarutis	Evergreen Legal Services; ABA Administrative Law Section

Commissioners, American Bar Association
Commission on Legal Problems of the Elderly

Lyman M. Tondel, Jr.	Commission chairman; partner, Cleary, Gottlieb, Steen & Hamilton
George J. Alexander	Dean, University of Santa Clara School of Law; chairperson, Family Law Section on the Elderly
Betty J. Capps	Consultant on Aging; formerly Administrative Officer, Divisions of Aging and Long Term Care for Colorado
Edward F. Howard	Member, Commission's Simplification Subcommittee; counsel, National Council on the Aging; formerly counsel, House Select Committee on Aging, oversight responsibility for programs and issues affecting the elderly
Esther F. Lardent	Director, Volunteer Lawyer's Project, Boston, MA; trainer for volunteer attorneys in legal issues affecting the elderly
F. Peter Libassi	Verner, Liipfert, Bernhard & McPherson; former general counsel for the Department of Health, Education and Welfare, responsible for drafting regulations affecting the elderly
Paul F. Nathanson	Chairperson, Commission's Simplification Subcommittee; professor, University of New Mexico Law Center; clinical coordinator for elderly programs; former director, National Senior Citizens Law Center, the Legal Services Corporation and Administration on Aging's back-up center for elderly litigation and legislation, nationwide
John J. Regan	Dean, Hofstra Law School; extensive research and writing on programs affecting the frail elderly
Daniel Skoler	Deputy Director, Social Security Administration Bureau of Hearings and Appeals, responsible for implementing programs affecting the elderly; responsible for drafting junvenile standards; former director, ABA Public Service Division
Fernando Torres-Gil	Professor, Andrus Gerontology Center, University of Southern California; former special assistant to Secretary of the Department of Health, Education and Welfare; former White House Fellow
Erica F. Wood	Former staff attorney, Legal Research and Services for the Elderly; former chairperson, Young Lawyers Division on the Elderly

Other Conferees

Nancy Coleman	Staff Director, ABA Commission on Legal Problems of the Elderly; former investigator with Senate Special Committe on Aging
Ina Coven	Commission legal intern
Bonnie Fought	Commission intern

[COMMITTEE PRINT]

FEDERAL RESPONSIBILITY TO THE ELDERLY

(Executive Programs and Legislative Jurisdiction)

CHARTS COMPILED BY THE CONGRESSIONAL
RESEARCH SERVICE OF THE
LIBRARY OF CONGRESS

FOR THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES
NINETY-FIFTH CONGRESS
SECOND SESSION
REVISED EDITION

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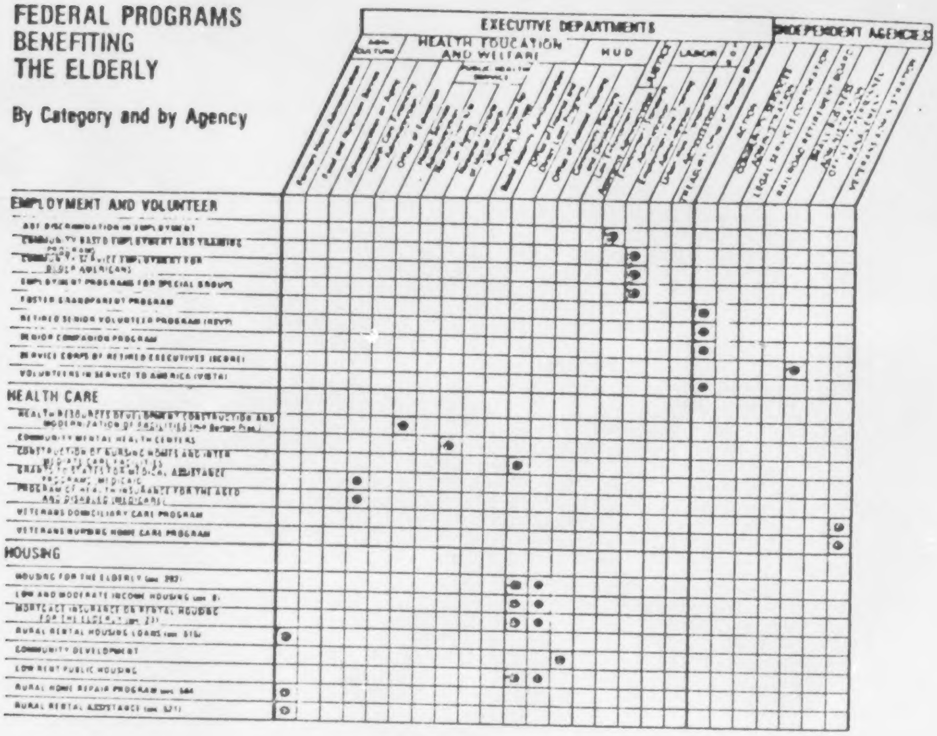
Washington, D.C. 20402

FEDERAL PROGRAMS BENEFITING THE ELDERLY

By Category and by Agency


EXECUTIVE DEPARTMENTS
INDEPENDENT AGENCIES
AGRICULTURE
HEALTH EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
HUD
LABOR

EMPLOYMENT AND VOLUNTEER

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- COMMUNITY BASED EMPLOYMENT AND TRAINING PROGRAMS
- COMMUNITY SERVICE EMPLOYMENT FOR OLDER AMERICANS
- EMPLOYMENT PROGRAMS FOR SPECIAL GROUPS
- FOSTER GRANDPARENT PROGRAM
- RETIRED SENIOR VOLUNTEER PROGRAM (RSVP)
- SENIOR COMPANION PROGRAM
- SERVICE CORPS OF RETIRED EXECUTIVES (SCORE)
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- GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS, MEDICAID
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- VETERANS NURSING HOME CARE PROGRAM

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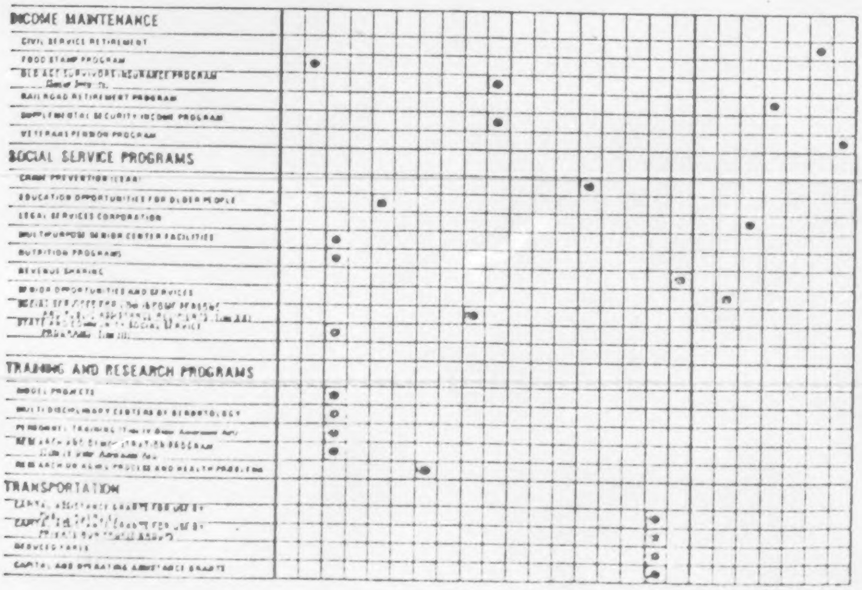
- LOW AND MODERATE INCOME HOUSING (sec. 8)
- MORTGAGE INSURANCE ON RENTAL HOUSING FOR THE ELDERLY (sec. 231)
- RURAL RENTAL HOUSING LOANS (sec. 515)
- COMMUNITY DEVELOPMENT
- LOW RENT PUBLIC HOUSING
- RURAL HOME REPAIR PROGRAM (sec. 504)
- RURAL RENTAL ASSISTANCE (sec. 521)



INCOME MAINTENANCE

- CIVIL SERVICE RETIREMENT
- FOOD STAMP PROGRAM
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- RAILROAD RETIREMENT PROGRAM
- SUPPLEMENTAL SECURITY INCOME PROGRAM
- VETERANS PENSION PROGRAM

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- REVENUE SHARING
- SENIOR OPPORTUNITIES AND SERVICES
- SOCIAL SERVICES FOR LOW INCOME PERSONS AND PUBLIC ASSISTANCE RECIPIENTS (Title XX)
- STATE AND COMMUNITY SOCIAL SERVICE PROGRAMS (Title III)

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- MULTIDISCIPLINARY CENTERS OF GERONTOLOGY
- PERSONNEL TRAINING (Title IV Older Americans Act)
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- REDUCED FARES
- CAPITAL AND OPERATING ASSISTANCE GRANTS

MOUNTAIN PLAINS FEDERAL REGIONAL COUNCIL
Federal Building ☆ Denver, Colorado 80202 ☆ 303-837 2741

SPAARS FACT SHEET

SPAARS (Single Purpose Application with Automatic Referral System) is an intergovernmental project exploring the feasibility and impact of a single purpose application for entry into the human services delivery system. The SPAARS goal is to facilitate the delivery of services to all clients legally qualified to receive such services by making the application process simpler and the referral easier. Development of a standard application would avoid the frustration and time consuming effort for the client to obtain the services needed.

SPAARS in a joint effort of the states of Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming with an inter-departmental group from the Mountain Plains Federal Regional Council (Region VIII), Denver, Colorado. The states of Massachusetts and Michigan joined SPAARS for the intergovernmental Eligibility Simplification project.

SPAARS was initiated to address the situation resulting when governments respond to the needs of the old, young, sick, blind, unemployed, and poor by enacting a variety of legislative remedies. This legislation has resulted in a number of complex policies, procedures and data processing systems. The increased complexity has created heavy administrative burdens and caused frustration among recipients, administrators, and the general public.

SPAARS Results

1. Single Purpose Application Colorado, Utah, Montana, and Wyoming each produced a standard application form by compiling common items of information requested of an applicatn form existing forms. Approximately 70% of the information called for in these existing application forms was uniform. The remainder was not common: either for unique program purposes or because essentially the same information was requested in a slightly different form. As a result of this analysis the Legal Constraints study was begun.

2. Legal Constraints study the Colorado and Federal teams completed a study to analyze the legal constraints imposed by Federal statutes and regulations to a standard application. Statutes and regulations for the Food Stamps, AFDC, Title XX, SSI, CETA, and Section 8 Housing Assistance programs were compared to determine the consistences and inconsistences in the treatment of financial need, ("income" and "resources") eligibility requirements. To resolve the inconsistencies language was proposed to revise the statutes and regulations. Statutes and regulations as of February, 1977 were the basis for this report.

3. Intergovernmental Eligibility Simplification project This project is a study to develop uniform measures for determining client financial need eligibility among human service programs. Changes are recommended in federal statutes and regulations to standardize the financial need requirements. An assessment is

is then made as to the likely impact of these changes on client program participation. The study reflects recent legislative and regulatory changes as of February 1980. The study concludes that standardization is feasible with most of the changes having miminal impact upon client participation and program benefit payments. Work on this project has been shared with the inter-departmental eligibility simplification project initiated by President Carter for the Department of Health and Human Services, Housing and Urban Development, Agriculture, Loabor, and the Community Services Administration and the Office of Management and Budget. This initative is co-chaired by HHS Secretary Parircia Harris and OMB Director James McIntyre.

Other SPAARS Results

1. A client pathway analysis was completed by South Dakota and Colorado to identify for each of the six above programs each event which occurs in the client eligibility determination process from the time the applicant files the application form to the final eligibility determination. All forms used in the process were identified.

2. Tie-Line was established in South Dakota as a state-wide and toll-free telephone information and referral system. Tie-Line operates by enabling a citizen to telephone the Tie-Line operator in the state capitol and discuss the citizen's need or problem with the Tie-Line operator who then consults a data base of public and private service providers. The Tie-Line operator then telephones the appropriate service provider treated closest to the caller and then bridges the caller with the service provider. The Tie-Line operator remains on the line long enough to assure that a proper linkage was make.

EXECUTIVE SUMMARY

Uniform Financial Measures For Use In Determining Client Eligibility Among Human Service Programs: An Impact Analysis is a remedy to solving administrative problems experienced by state and local governments in delivering human services. The study, which focuses on one element of the structure of human service programs (i.e., the client eligibility determination process and the development of ways to simplify Federal eligibility requirements) outlines a systematic approach to making the human service delivery system more efficient, effective and equitable. Through this study, national government is provided with a framework for developing national policy regarding the income and resources of individuals and families in need. The study proposes a comprehensive set of language that (1) provides for uniform, national definitions of income and resources and (2) provides for uniform policies regarding the process used in human service programs for valuing and treating the income and resources of persons in need. While the language proposed necessitates changes in program laws and regulations, such changes are necessary if government is to respond effectively to state and local governments, taxpayers, and clients.

Study Overview

The study of Federal eligibility requirements indicates it is possible to achieve uniformity and consistency among the various sets of definitions that exist among human service programs. This study focuses exclusively on the development of uniform language to define the terms income and resources. The study compares and identifies the differences that presently exist among definitions of income and resources as cited in the laws and regulations of six programs: Food Stamps, Supplemental Security Income (SSI), Aid to Families with Dependent Children (AFDC), Title XX of the Social Security Act, Comprehensive Employment and Training Act (CETA), and Section 8 Low-Income Housing Assistance. The study further examines the effects of using uniform definitions of income and resources to determine client eligibility on the participation rates and benefit levels of selected programs. Based on this preliminary assessment, it appears that the use of uniform measures to determine income and resources would not create significant changes in the number of persons deemed eligible for program benefits, nor would benefit levels of current recipients be altered significantly.

Funded by the Community Services Administration, the study represents a joint activity of the States of Colorado, Massachusetts, Michigan, and South Dakota in conjunction with the Mountain Plains Federal Regional Council, Region VIII.

Recommendations

Outlined in this study are specific recommendations for defining, valuing, and treating each type of income and resources identified in the course of analysis. In order that uniformity among federal definitions of income and resources be achieved and methods used by states to deliver human services be streamlined and simplified, the following actions are recommended:

1. That the Department of Health and Human Services, Housing and Urban Development, Labor and Agriculture in conjunction with the Office of Management and Budget develop a federal policy which provides for the use of uniform standards for evaluating and treating the personal finances of individuals and families applying to social and economic programs.

2. That the proposed changes and recommendations cited in this document be utilized and considered in the course of formulating such federal policy.

3. That such federal policy be used as guidance for departments and agencies in issuing federal regulations.

4. That the Office of Management and Budget assume the responsibility to review regulations issued by federal departments and agencies in order to assure compliance with such federal policy.

5. That the Office of Management and Budget require all legislative proposals submitted by the President to the Congress comply with measures delineated in such federal policy.

6. That the Department of Health and Human Services, Housing and Urban Development, Labor, and Agriculture in conjunction with the Office of Management and Budget begin developmental work toward the design and development of a comprehensive data system which provides useful and consistent information regarding the characteristics of populations of social and economic programs.

TABLE II

Statutory and/or Regulatory Changes Needed to Standardize

Programs / Category or Item	Food Stamps	SSI	AFDC	Title XX	CETA	Section 8 Housing
1. Income from Employment	A	A*	A	A	B	A
2. Net Income from self-employment	B	B*	B	B	B	B
3. Military Pay	A	A	A	A	A	B
4. Earinings of a child/student	B*	B*	B*	B	A	A
5. Unemployment Compensation	A	A	A	A	B	A
6. Worker's Compensation	A	A	A	A	A	A
7. Strike Benefits	A	A	A	A	A	A
8. Veterans' Compensation	A	A	A	A	B	B
9. Retirement Benefits	A	A	A	A	A,B	A,B
10. Social Security Benefits	B	B	B	B	B	B
11. Disability Benefits	A	A	A	A	A	A
12. Educational Benefits	B*	B*	B	B	B	B
13. Loans	B*	A	B	N/A	A	A
14. Refunds	A	B*	A	N/A	N/A	A
15. Third Party Payments	B	B	A	A	A	A
16. In-kind Income	A	B*	A	A	B	A

A=Language change; no change in substantive policy
B=Language and substantive policy change
N/A= not applicable

* refers to a change in both statute and regulation Items without an asterisk indicates the change is

TABLE II

Category or Item \ Programs	Food Stamps	SSI	AFDC	Title XX	CETA	Section 8 Housing
17. Support Payments	A	B*	A	A	B	A
18. Alimony Payments	A	B*	A	A	A	A
19. Foster Care Payments	A	A	A	A	A	A
20. Irregular Income	B*	B*	N/A	N/A	N/A	B*
21. Prizes, Gifts, Awards	A	A*	A	B	A	A
22. Annuities	A	A	A	A	A	A
23. Inheritances/ Trusts/Estates	A	A	A	A	A	A
24. Proceeds from Insurance Payments	B	B	A	A	A	A
25. Royalties	A	A	A	A	A	A
26. Dividends and Interest	A	A	A	A	A	A
27. Income from Rents	B	B*	A	A	A	A
28. Income from the Sale of Property	A	A	A	N/A	N/A	A
29. Home Produce	A	A	A	A	A	A
30. Pensions	A	A	A	A	A	A

TABLE II

Category or Item \ Programs	Food Stamps	SSI	AFDC	Title XX	CETA	Section 8 Housing
31. Assistance Payments from Government Programs/ Payments Provided by other Federal Statutes						
a. WIC	A	A	A	A	A	A
b. Benefits under the Uniform Relocation Assistance and Real Property Acquisitions Policy Act	A	A	A	A	A	A
c. Earned Income Tax Credit	B	B	B	B	B	B
d. Payments under the Youth Incentive Entitlement Project, and Title IV, CETA	B	B	B	B	B	B
e. Value of the Food Stamp Coupon allotment	N/A	A	A	A	A	N/A
f. Benefits under the National School Lunch Act	N/A	A	A	A	N/A	N/A
g. Benefits under the child Nutrition Act	N/A	A	A	A	N/A	N/A

TABLE II

Programs Category or Item	Food Stamps	SSI	AFDC	Title XX	CETA	Section 8 Housing
h. Grants or loans made to an Undergraduate Student under programs administered by the Commissioner of Education	A	B	B	B	A	A
i. Incentive Allowances under Title I, CETA	A	B	B	B	B	B
j. Benefits under Title VIII, Nutrition Program for the Elderly	N/A	B	B	N/A	N/A	N/A
k. Value of USDA donated foods	N/A	A	A	A	N/A	N/A
l. Public assistance or Welfafe Payments	A	A	A	A	B	A
m. Payments under the Trade Readjustment Act					B	
n. Payments under the Disaster Relief Assistance Act	B	B	B	B	B	B
o. State Payments basea on age and Duration of residence	A	B	A	A	A	A

TABLE II

Programs Category or Item	Food Stamps	SSI	AFDC	Title XX	CETA	Section 8 Housing
p. Payments under the Alaska Natives claims Settlement Act	B	B	B	B	B	B
q. Payments under P.L.94-114 and P.L.94-189 (payments to Indain tribes)	B	B	B	B	B	B
r. Soil Bank Payments					B	
s. Agricultural Crop Stabilization payments					B	
t. Benefits under the Crisis Intervention Program	B					
u. Indian Lands	A	A	A	A	A	A
v. Payments under P.L.94-540 to the Grand River Band of Ottowa Indians	B	B	B	B	B	B
w. Amount of the Supplementary Medical Insurance Prenium under Title XVIII of the Social Security Act						

TABLE II

Programs / Category or Item	Food Stamps	SSI	AFDC	Title XX	CETA	Section 8 Housing
x. Payments to the Blackfeet and Gros Ventre Tribes	B	B	B	B	B	B
y. Indian per capita Payments under P.L. 93-134	B	B	B	B	B	B
z. Value of Housing assistance under P.L. 93-375	B	B	B	B	B	B
aa. Value of advice, counseling consultation, training	N/A	A	N/A	N/A	N/A	N/A
bb. First $%5 of Earned Income	N/A	N/A	B	N/A	N/A	N/A
cc. Training incentives Section 632 Title IV, Social Security Act	B	B	B	B	B	B
dd. Reimbursements	A	B	B	B	B	B
ee. Payments made to volunteers under the Domestic Volunteer Services Act						

TABLE II

Category or Item \ Programs	Food Stamps	SSI	AFDC	Title XX	CETA	Section 8 Housing
1. Cash on Hand	A**	A**	A**	N/A	N/A	A
2. Checking Accts	A**	A**	A**	N/A	N/A	A
3. Savings Accts	A**	A**	A**	A	N/A	A
4. Stocks, Bonds	A**	A**	A**	N/A	N/A	A
5. Mutual Fund Shares	A**	A**	A**	N/A	N/A	A
6. Promissory Notes and Mortgages	A**	A**	A**	N/A	N/A	A
7. Income Producing Property	A**	A**	A**	N/A	N/A	A
8. Motor Vehicles	B*	B*	B*	N/A	N/A	A
9. Home	B*	B*	B*	N/A	N/A	N/A
10. Household Goods and Personal Effects	B*	B*	B*	N/A	N/A	A
11. Life Insurance Policies	B*	B*	B*	N/A	N/A	A

the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on
National Health Security

MCR-34

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

NATIONAL HEALTH SECURITY

Sponsored by:

National Council of Senior Citizens
National Retired Teachers Association
American Association of Retired Persons

Co-Sponsors:

AFL-CIO, Associacion Nacional Pro Personas Mayores, Gray Panthers, National Center on Black Aged, National Council on Aging, United Auto Workers

Submitted by:

National Senior Citizens Education and
Research Center
1511 K Street, N.W.
Washington, D.C. 20005

Washington, D.C.
January 15, 1981

Mini-Conference Coordinator

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White House Conference on Aging Staff

Publications Coordinator

Stephanie Braime
White House Conference on Aging Staff

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Appendix 1 Health Recommendations of the 1971 White House Conference on Aging ....

Introduction

On January 15, 1981, more than 350 seniors from across the country attended a White House Conference on Aging Mini Conference on National Health Security. The Mini-Conference was held at the Capital Hilton in Washington, D.C.

Throughout the day, participants listened to expert speakers, reviewed the strengths and weaknesses of the American health care system, and considered possible alternatives. In the end, they unanimously adopted a five-page declaration which called for reforms and establishment of a national health security plan. The Mini-Conference on National Health Security was one of more than three dozen mini-conferences on as many different issues taking place in preparation for the 1981 White House Conference on Aging in December. These meetings were designed to focus national attention on special aging issues--issues affecting special populations or issues which would not be treated in depth through the general process of local, state, and regional meetings leading to the national conference November 30-December 3, in Washington, D.C.

The Mini-Conference on National Health Security was sponsored by the National Council of Senior Citizens, the National Retired Teachers Association and the American Association of Retired Persons, and was cosponsored by the AFL-CIO, Asociacion Nacional Pro Personas Mayores, the Gray Panthers, National Center on Black Aged, the National Council on the Aging, and the United Auto Workers.

The Mini-Conference was organized as a plenary session, with a succession of speakers and a final period for consideration of and action on a conference declaration. The first chapter of this report provides an overview of selected issues, a review of the growing role of public funds in health financing, a summary of the elderly's health status, and the meeting's response. The second chapter reviews the proceedings of the Mini-Conference; and the third chapter details the declaration. In an appendix is provided a selection of health recommendations from the 1971 White House Conference on Aging.

Chapter 1 -- In Search of National Health Security

Fifteen years after the enactment of Medicare, frustration is growing over its failures and shortcomings, and pressure is mounting for remedies and for greater public funding of health costs for all Americans. The result is continuing demand for some form of national health security.

Medicare's problems are numerous:

° It fails to cover the greatest medical need of the elderly--long-term care for chronic diseases and disabilities.

° Its arbitrary limits on the length of time services will be paid are unrealistic for the needs of the elderly.

° Its co-payment features encourage delay in seeking care and thus discourage preventive measures.

° It has been plagued by the problems of provider fraud and abuse which generally characterize the health delivery system.

° Its lack of cost controls have at least in part contributed to precipitous rises in health care spending.

Furthermore, the American health care system is highly fragmented; it is unevenly distributed; and it is preoccupied with acute care rather than preventive medicine.

The combination of Medicare's deficiencies and the health system's shortcomings has led many who are advocates of improved health care for the elderly in search of national health security plans. The search has been an ongoing one--the 1971 White House Conference on Aging recommended "a comprehensive health care plan for all persons"--and promises to be a continuing one.

"This issue is probably the most important, controversial, and difficult one confronting the decade to come," WHCOA Executive Director Jerome R. Waldie told the 1981 Mini-Conference on National Health Security.

Mini-Conference participants reacted by unanimously adopting a declaration which called for health care system reforms and establishment of a national health security plan.

Background

Public funding of health care is nearly as old as the Republic, dating from when the Public Health Service was established to provide care and treatment for merchant seamen. The population was a select one, and services were provided to it on a targeted basis.

Expansion of publicly funded health care to another targeted group was used after World War I in providing care to veterans through federal hospitals and doctors of the Veterans Administration. In these two cases, federal funds were used to provide care directly. When the next expansion of public funding for health care occurred--through Medicare and Medicaid for the elderly and poor--government funding was combined with coverage by private health insurers, an industry that developed in the 1930s and '40s. As each step was taken, the role of public funding increased.

Just before Medicare and Medicaid, for example, about 20 percent of the nation's health care costs were paid by public funds; 10 years later, in 1975, 40 percent of the costs were publicly financed.

Despite the existence of Medicare, the elderly's out-of-pocket health care spending has increased substantially. While Medicare was originally intended to cover 80 percent of physician fees and hospital fees for the elderly, in 1978 only 55 percent of physician fees and 74 percent of hospital charges were covered. In addition, many supportive services are not included, such as eyeglasses, hearing aids, dentures and out-patient prescription drugs; and for a population beset by chronic conditions, the emphasis has been on coverage for short-term acute illnesses and accidents.

The Elderly's Health Care

The country's population is living longer. In 1979, longevity had increased to 73.8 years for the American population. Not everyone, however, has reaped the benefits of this gain in longevity. Minority groups have not fared as well in the statistics. Life expectancy for non-whites is five years less than for whites.

More persons are surviving to the upper age brackets than ever before. Seventy-five percent of Americans living today will reach age 65, compared to 40 percent in 1900. This is important because per capita expenditures for personal health care services increase sharply with age.

Although they account for 11 percent of the population, the elderly account for almost one-third of the nation's health expenditures, because of their greater need for health services and the costlier nature of their illnesses. They require more physician time; they have more frequent hospital admissions and longer hospital stays; they are the major users of long-term care facilities and home health agencies; and they consume one-fourth of all drugs purchased.

It is obvious that major gaps exist for the elderly in health manpower and health services. Geriatric medicine is not recognized as a medical specialty in the United States; yet, on the average, 40 percent of an internist's patients are 65 or older and 60 percent of the internist's time is spent with them. Service gaps exist in areas of major medical need such as home health care, long-term care, rehabilitation, and preventive services.

Response of the Mini-Conference

The five-page declaration adopted unanimously by the Mini Conference on National Health Security reviewed the failure of the promises of the 1971 White House Conference on Aging and the shortcomings of the health system, and pledged a renewed effort for enactment of a national health security plan.

Its assessment and recommendation were captured in two key paragraphs:

° Assessment: The inescapable conclusion is that significant reform of the health delivery system is required to meet the goals of financial protection of patients, equal access to medical care, equitable distribution of health care resources, improved quality and appropriateness of health care, and increased participation in the system by all of us who pay the national health bill.

° Recommendation: A national health security plan, built upon a broad-based and progressive financing mechanism, should be established to assure comprehensive, uniform protection and high quality health services for all people.

Mini-Conference on National Health Security

Capital Hilton Hotel, Washington, D.C., January 15, 1981

Agenda

9:30 A.M. The Need for National Health Security
Esther Peterson, Chairperson
Special Assistant to the President for
Consumer Affairs

Keynote: William Duncan
Executive Assistant to Bayard Rustin
Chairman of the Board
A. Philip Randolph Institute

10:00 A.M. Health Care for the Elderly
Bert Seidman, Chairperson
Director, Social Security Department, AFL-CIO

View of the Patient
Nelson H. Cruikshank, Moderator
Former Chairperson, Federal Council
on Aging

Panel Members:

America Nelson, Member, National
Center on Black Aged
Milton Wilkotz, State Coordinator
American Association of Retired
Persons/National Retired Teachers
Association
Max Serchuk, President, Florida State
Council of Senior Citizens

View from the Health System

Victor E. Sidel, M.D., Speaker
Professor and Chairperson, Department of
Social Medicine, Montefiore Hospital,
Albert Einstein College of Medicine,
Bronx, New York

12:15 P.M. Luncheon (Presidential Room)

Impetus for Action -- National Picture

Donald F. Riley, Chairperson
Deputy Director, National Council on the Aging

Dr. John Holloman, Speaker
Former Member, Professional Staff, Health Subcommittee, House Ways and Means Committee

2:00 P.M. Older Women and Health Care
Tish Sommers, President, Older Women's League Educational Fund

2:30 P.M. Problems and Principles for Solution
Mel Glasser, Director, Committee for National Health Insurance

3:15 P.M. An Action Program
Cyril F. Brickfield, Chairperson
Executive Director, National Retired Teachers Association - American Association of Retired Persons

Conference Recommendations
Jacob Clayman, President, National Council of Senior Citizens

Chapter 2 -- Report on the Mini-Conference

More than 350 delegates, mostly elderly, from across the country braved one of Washington, D.C.'s infrequent winter snowstorms and attended the Mini-Conference on National Health Security on January 15, 1981, at the Capital Hilton Hotel. The snow snarled traffic, delayed the conference, and blocked the appearance of Bayard Rustin of the A. Philip Randolph Institute as the keynote speaker.

The Mini-Conference was sponsored by a consortium of groups. The sponsors were the National Council of Senior Citizens and the National Retired Teachers Association and American Association of Retired Persons. Cosponsors included the AFL-CIO, Asociacion Nacional Pro Personas Mayores, the Gray Panthers, the National Center on Black Aged, the National Council on the Aging, and the United Auto Workers. Conference participants listened as a number of speakers outlined the current state of the country's health care system, the health care needs of the elderly, and the need for national health security. Then after debate, the participants unanimously adopted a declaration on national health security which called for establishment of a national health security plan "built upon a broad-based and progressive financing mechanism...to assure comprehensive, uniform protection and high quality health services for all people."

The conference was opened by Esther Peterson, Special Assistant to the President for Consumer Affairs. Ms. Peterson emphasized the need for the participation of the consumers in the decision making. She set the tone of the conference with her statement that many of the problems associated with the current health care system could be alleviated by the establishment of a national health security plan. A plan that would ensure comprehensive, uniform protection and high quality health services for all people.

In the keynote address, Will Duncan, Executive Assistant to Bayard Rustin, outlined the need for national health security. Citing gaps in present insurance coverage, and Canada's experience in broadened coverage and lower costs under a national health insurance program, Duncan said, "There is a crying need for adequate comprehensive health insurance and health coverage in this country." Those who have the least coverage--or none at all--are predominately the working poor and unemployed, of whom blacks and hispanics make up a disproportionate number.

Duncan cited the following benefits from the Canadian system:

° Coverage expanded from 70 to 99 percent.

° Mortality rates have fallen.

° In comparison with the United States, Canadian administrative rates are about 15 percent of American rates, and Canadian health care expenditures as a percentage of Gross National Product (GNP) are lower than American (Canadian: 7% v. U.S.: 9.2%), despite some rise in Canadian health spending under health insurance.

"No social issue should have a higher priority," Duncan said, "than the enactment of a comprehensive national health insurance program. America remains a country of 'haves' and 'have-nots'; we must not allow it to remain a country of 'live' and 'live-nots.'"

Health Care for the Elderly

From the varying perspectives of the patient, older women, and the health system, a panel of elderly speakers described encounters of the elderly with the health care system.

The Patients' View: Three speakers described the encounters of patients with the system in a panel discussion moderated by Nelson H. Cruikshank, former Counselor on Aging to President Carter.

America Nelson, a 74-year-old retired teacher, described a continuing effort, which began in 1975, to provide adequate care for her mentally ill husband. The two have played a see-saw battle with health care costs and annuity benefits, in which a rise in benefits would be exceeded by a rise in costs. Over the years, costs have more than doubled, she said, going from $630 a month to $1,440 a month. Her family's savings have long been exhausted by the ordeal, she said. "It is a sad indictment of our system," she said, "that those who have worked all their lives in professional careers are reduced to poverty in their retirement."

Milton Wilkotz, a New Jersey furniture salesman, described what happened when his wife suffered a major heart attack while his insurance coverage had inadvertently lapsed. "We had all kinds of coverage, including major medical. I had changed jobs, but I still thought I was under the contract. So when she went into emergency, I presented the Blue Cross/Blue Shield card, which turned out to be the wrong card to present. I was called by the hospital the following day--when my wife was in the coronary care unit--and told to have $500 ready 'or we'll have to to something about your wife.' When I had changed jobs, I wasn't smart enough to take insurance out personally. My wife's case is just one sample case where I find myself as the recipient of the inadequacies of our health system. It's costly to me; and I'm over 60 and about ready to retire in another five years; but I won't have any money left to retire with."

Max Serchuk of Miami, Florida, President of the State Council of Senior Citizens, described some of his experiences as a member of the South Florida Health Systems Agency. He recounted hospitals' efforts to acquire expensive new equipment even when the same equipment in other hospitals was still underutilized. He told also of patients' inability to follow doctors' instructions because of the patients' low incomes and shortfalls in coverage from Medicare. "It's about time those tools were provided," he said, "the dentures, the hearing aid, the eyeglasses--so they can carry out the orders of the doctors. Otherwise half our services are going for nothing."

The Older Woman's View: Tish Sommers of the Older Women's League Educational Fund described shortcomings in the health care system for older women, whom she characterized as those women between menopause and Medicare. She singled out three particular problems. One was the gap in medical specialties between a woman's reproductive years--when a gynecologist is many women's primary physician--and the time some years later when she needs special geriatric care. "Although midlife women are subject to the onset of chronic illness," she said, "there is little specific attention or public money directed to this time of life, yet this is the period when preventive health programs could be most fruitful to reduce disability or high medical costs later on." Another special problem she cited was the woman's loss of health coverage through divorce or widowhood. Some four million women 46 to 65 are without any health insurance at all, she said. And she described her own experience with a recurring cancer shortly after her divorce but prior to her eligibility for Medicare. "I learned first hand what catastrophic cost means," she said. The third problem was the absence of adequate training for women in home health care, despite her assertion that women in the home are "the nation's primary health care providers." "Of the non-institutionalized elders," she said, "more than three-quarters of those requiring personal care receive it from a relative, usually female."

The Health System's View

Dr. Victor E. Sidel, Chairman of Social Medicine at Montifiore Hospital in New York, used a series of charts and pictures in giving statistical evidence that health care in America "is enormously expensive--higher than any other country in the world." He said that even with Medicare, older people still are paying far more than people in other countries, and more than they paid before Medicare was enacted. And the elderly poor pay a higher percentage of their income for care than the non-poor," he said. He also described efforts to organize the neighborhood around Montifiore so residents could have greater roles in health maintenance and in routine procedures, such as monitoring blood pressure.

Proposals for Changes

Having first examined some of the health care system's problems, the Mini-Conference next turned to an examination of possible improvements. Dr. John Holloman, formerly on the Health Subcommittee staff of the House Ways and Means Committee, urged the participants to take action soon in support of appropriate legislation. "If we're going to fulfill the great promise of the American dream," he said, "the time to do it is now. Go back to your homes and to your organizations and let everybody know how you stand on this important issue." "Health care for all Americans is a matter of right," he continued, "and one of the ways in which we can claim it is by passing legislation which will guarantee reality out of the rhetoric we hear so often."

Cyril F. Brickfield of the American Association of Retired Persons continued the same theme. Picking up on an allusion to Dr. Martin Luther King, Jr. (whose birthday celebration coincided with the Mini-Conference) as a drum major for justice, peace and righteousness, he said, "Perhaps all of us in our own ways can become drum majors for justice in health care. Some day we shall look back on these times in wonderment that the unjust systems of civil liberties, and of voting, and of health care ever existed as long as they have." "It's inevitable," he said, "that your children and my children will someday experience a health system that cares more for people than for profit, and that cares equally for all of us."

Mel Glasser of the Committee for National Health Insurance described two proposals, which he rejected as "major threats," and a third set of principles which he said were needed "to protect ourselves and to get the right kind of a program." One of the unacceptable proposals, he said, was designed to cover only catastrophic health expenses above a certain maximum which would be paid by the individual. "It has no cost controls; it has no quality controls; it means that prices will go up because the only way that the services will be paid for is if you get above that barrier. Since there is no limit on what the doctor or what the hospital can charge, the incentive is to charge more." Another unacceptable proposal, he said, is the pro-competition plan. "Pro-competition plans do nothing for about 1/4 of the population who have no insurance coverage. It's a form of insurance for those who have insurance...The proponents of this plan say that this is a very good system because it will encourage competition. It will encourage competition to offer cheaper and cheaper plans, but not cheaper and cheaper prices because we do not have a free market in the health industry...and then finally, these pro-competition plans boast of the fact there will be no further quality controls in the program, they will strip away the professional service review organization, the accreditation of hospitals and other interferences with the free enterprise system."

"These are the two major threats that we face as we try to move forward," he continued. "We have got to make sure that we don't move backwards, and we will need help and cooperation to deal with these issues."

The principles he recommended provided for universal coverage, comprehensive benefits, effective cost controls, effective quality control, and reorganization of the delivery system. "I'm saying to senior citizens, as I say to all citizens," he concluded, "we must have reform of the health care system; we must get to national health insurance; and we can get to it if we know what we're after and we organize to fight for it."

Agreement for Action

In the final session of the Mini-Conference, Jacob Clayman of the National Council of Senior Citizens presided over consideration of a declaration on national health security.

A five-page draft declaration was available for discussion, and drew a number of comments in debate. The strongest comments were aimed at severely restricting the role of private insurance companies, at stressing the inclusion of long-term care, and at preserving public general hospitals and other public health facilities pending the adoption of a national health security plan. Among those making statements or proposing amendments were representatives of the United Auto Workers, the Congress of Senior Citizens of Greater New York, the Gray Panthers National Health Task Force, the Chicago Coalition for National Health Service, Maryland Advocates for the Aging, and the National Center on Black Aged.

As adopted, the declaration reviewed the shortcomings of the present health care system, concluded that "significant reform of the health delivery system is required," and proposed a national health security plan which would provide for universal coverage, comprehensive benefits, cost controls, quality assurance, health care system reform, and adherence to social insurance principles in administration and financing.

Chapter 3 -- Declaration of the Mini-Conference

In its final session, the Mini-Conference on National Health Security unanimously adopted a declaration which identified the major health care problems of the elderly, explained why the problems exist, and proposed a national health security plan which would respond to the problem. The text of the declaration follows.

Background

In 1971, the White House Conference on Aging made recommendations for health care which would have improved the access, delivery, and financing of health services to the elderly. The problems confronting the elderly population in 1971 were due to the lack of comprehensive health care services; insufficient attention to all the needs of the elderly--physical and mental, acute and chronic, particularly for those who are isolated or poor; and a financial mechanism that guaranteed financial protection to the provider of services instead of the consumer.

Now, as we prepare for the 1981 White House Conference on Aging, it is sad to report that, in spite of the gains which the elderly have achieved in some areas, they face many of the same health care problems as they did in 1971. The major problems which existed in 1971 have not been solved. Not only are the problems of a decade ago still with us, but they have grown. They are likely to become even more severe unless dramatic steps are taken and taken soon.

Health Care Problems

1. Health care is not available to all people even though it is a basic necessity of life

Millions of Americans are unable to receive health care services in spite of the availability of public and private insurance programs, and in spite of the fact that health care in the United States is supposed to be among the best in the world. Over 26 million Americans have no health insurance coverage at all, public or private. They are the unemployed, the working poor, and other low-income people who do not qualify for Medicaid.

As many as 50 million Americans have inadequate health care coverage. Moreover, many elderly who require services that have only limited coverage under Medicare are inadequately protected. For example, mental health benefits are more limited than other covered services. Clearly the approach used today fails for too many people.

2. The mode of health care may not be the most efficient and effective

What we have today is not health care: It is sick care. People are hospitalized when they could be effectively treated as outpatients; they are over-medicated, over-diagnosed, and over-charged; and little concern is given to helping people maintain good health and prevent illness.

3. There is a poor distribution of the health care resources we have

Not only are they unevenly distributed across the population, but also they are biased toward specialization and the use of high technology medicine. Primary care, the care needed most often by most people, is inadequate. This inadequacy is felt particularly by the elderly who need readily accessible primary care not only to maintain well-being but to prevent minor symptoms from developing into acute conditions.

4. Health care costs are outpacing other consumer expenditures

From 1970 to 1979, the Consumer Price Index rose 87 percent for all items, while medical care service charges rose 200 percent. The elderly in particular have felt the effects of the increasing costs of medical care, in spite of the existence of Medicare. In 1978, medical bills for persons age 65 and over averaged $2,026 per person, compared to $764 for those aged 19 to 64, and $286 for those under age 19. In 1981, the average bills for the elderly are expected to reach $2,500 or more.

5. The increased cost of health care is crowding out other desirable uses of our national resources

Total national expenditures for personal health care in 1979 was $212.3 billion. This represented 9 percent of the Gross National Product (GNP) as compared to 8.3 percent as recently as 1975 and 4.6 percent in 1950.

This is happening not so much as the result of significant improvement in the quality of health care, but as the consequence of price increases due to a lack of effective cost containment attempts. It means the rationing of medical care on the basis of one's ability to pay.

Why The Problems Exist

Basically, the problems are a result of the way the health care industry works:

First, providers make nearly all the decisions about the type, quality, and quantity of care provided. This means that the medical care system can absorb every dollar available to it by providing more and more elaborate technology and treatment--even if it does not increase the health of the nation.

Second, widespread public and private third-party reimbursement insurance provides almost open-ended financing to the medical care system. Therefore, neither the provider nor the patient, when the patient has financial coverage, has any incentive to seek low-cost treatment, even when it may be equally as effective as high-cost treatment.

Resolution on a National Health Security Plan as Unanimously Adopted by the Mini-Conference Follows

"A national health security plan, built upon a broad-based and progressive financing mechanism, should be established to assure comprehensive, uniform protection and high quality health services for all people."

"Specifically, this plan would provide for:

1. Universal Coverage: All people would be eligible under the plan, without regard to age, health status, income level, or employment status. Access to health care would not be limited by deductibles, cost-sharing, or co-payments.

2. Comprehensive Benefits: Benefits should include not only full coverage for the acute care services of hospitals and physicians, but also nursing homes, home care and related community services for the elderly and disabled requiring long-term care. Benefits should include a wide range of services such as preventive care, appropriate social/medical services, health maintenance and teaching people how to keep well. Also included should be such services as preventive physical and mental health services, medications, dental care, eye care and foot care.

Pending enactment of a national health security plan, a complete range of physical and mental health services should be provided to the elderly by expanding Medicare legislation.

In addition, current public health facilities and public general hospitals should be preserved and extended as indispensable sources of health care for millions of Americans of all ages.

3. Cost Controls: Mechanisms such as prospective budgeting should be built into this plan in order to foster control over the rising costs of health care.

4. Quality Assurance: Controls which assure that minimum standards of quality are being met in the delivery of care must be a part of the plan to ensure that quality is not compromised.

5. Health Care System Reform: Alternative methods of financing or providing services, such as those exemplified by health maintenance organizations and community health centers and clinics would be covered under this plan in order to encourage cost-savings and improved quality in service provision.

6. Adherence to Social Insurance Principles in Administration and Financing: All people would be entitled to participate in this health plan without an income test requirement. No important role will be given to the private insurance sector in the National Health Security plan. The risk of underwriting such a plan will be borne by the federal government, not the private sector.

Third, the incentives at work today encourage providers toward specialized, high-technology, high-cost care. In part, it is a result of the reimbursement system which, for instance, may cover the costs of care provided in a hospital but not in a doctor's office. In part, it is the fault of a system which permits the practitioner to make decisions without regard to the costs, appropriateness or quality of care and without bearing any of the risks. The medical care provider can get rich by providing elaborate sick care; in general, the provider gets little or nothing for keeping people well. Thus providers have no incentive to use health resources efficiently.

Fourth, the consumer is in no position to judge the effectiveness or efficiency of medical care, particularly at times of illness, and thus offers no check on the decision-making of the provider.

Fifth, the medical system has no ongoing mechanism for monitoring patient outcomes, nor is any provider accountable for the patient's health beyond individual services rendered. Thus the system will tend to maximize services rather than health.

The inescapable conclusion is that significant reform of the health delivery system is required to meet the goals of financial protection for patients, equal access to medical care, equitable distribution of health care resources, improved quality and appropriateness of health care, and increased participation in the system by all of us who pay the national health bill.

In order that this National Health Security plan be both efficient and effective, it must be enacted as a total plan."

In conclusion

The discussion which took place at the Mini-Conference indicated a clear and indeed unanimous view that something is seriously amiss with our current system of medical care and its delivery. The delegates enthusiastically turned to a national health security plan as the best means of solving the problem of quality, cost and adequacy of health care in America.

Appendix 1 -- Health Recommendations of the 1971 White House Conference on Aging

To be specifically responsive to the needs of the elderly, special attention must be given to the availability and quality of long-term care and to the development of adequate, appropriate alternatives to institutional care.

Community and consumer participation in the planning and delivery of such a system of services will tend to assure the responsiveness of the system to locally defined community need and the appropriate use of health manpower, facilities and financing.

The Health Section recognizes that although the aged represent a minority, within this minority there are special problems experienced by racial and ethnic groups. Within the special concern expressed for the problems of the aged, particular attention must be accorded to make sure that these minorities are not doubly jeopardized.

In support of these basic premises, the Physical and Mental Health Section submits the following policy proposals:

RECOMMENDATION I--Special Health Care

Health care for the aging must be provided as an integral part of a coordinated system that provides comprehensive health services to the total population, but immediate and special consideration and emphasis must be given to the problems of, and services for, the aging.

RECOMMENDATION II--Coordinated Health Services Delivery System

A coordinated delivery system for comprehensive health services must be developed, legislated, and financed to ensure continuity of both short- and long-term care for the aged.

RECOMMENDATION III--National Health Insurance and Medicare

A comprehensive health care plan for all persons should be legislated and financed through a national health plan. Pending the achievement of such a national health plan, the complete range of health care services for the elderly must be provided by expanding the legislation and financing of Medicare. Such expanded financing should be accomplished by means of a combination of Social Security trust funds with a greatly expanded use of general revenues. Such expansion of Medicare should include elimination of deductibles, co-insurance and co-payment, and all provisions discriminatory to the mentally ill, as well as the establishment of congruent ages for Medicare and Social Security benefit eligibility. Both the immediate expansion of the current program and a future national health plan should provide for a public-private partnership in the delivery of services and for Federal financing and quality controls in order to assure uniform benefits and uniform application of the standards of quality. Centralized responsibility for standards and controls over health facilities and services must be combined with protection, for the patient and provider, from arbitrary, capricious, and varied application and interpretation of existing as well as new standards.

Minority Recommendation

The fiscal aspects of the Medicare program should be administered by the Federal government rather than by the private insurance carriers as intermediaries.

RECOMMENDATION IV--Health Education for All Ages

A continuing national program for education of all persons should be provided about the specific physical, mental, and social aspects of aging. Educational programs should be addressed to all ages and should include all stages of development so that the different age groups will better understand each other. Information on all aspects of aging should be included in educational courses at all levels. The aged themselves should be among those recruited, trained, and utilized in carrying out these programs.

RECOMMENDATION V--Training in Aging for Health Manpower

Emphasis should be placed on including curricula or course contents on physical, mental and social aspects of aging in secondary schools, undergraduate professional education, and in in-service training and continuing education of health personnel. The development of specialists in the care of the elderly should also receive emphasis, especially with the view of developing professional, allied health professional, and other health personnel selected and trained to give compassionate and expert care to the aged. Funds must be provided to ensure the development of such programs as well as increase the supply of health manpower of all kinds.

RECOMMENDATION VI--Funding for Research, Service, and Education

The aging will best be served if available funds are divided among service, research, and education. Emphasis should be placed on funding of direct services but not to the exclusion of research and education, which should receive a reasonable proportion of total resources available. Research findings now available should be assembled, coordinated, and incorporated into service programs.

Specific attention should be given to increasing the funds available for basic research and for operational research with a strong suggestion that a gerontological institute be established within the National Institutes of Health to provide the essential coordination of training and research activities.

RECOMMENDATION VII--National Mental Health Center for Aging

A center for aging should be established in the National Institute of Mental Health to meet the responsibilities for more research and training in the field of mental health of the elderly.

RECOMMENDATION VIII--Presidential Commission on Aging

The President and Congress should authorize the appointment of a commission on aging, including a committee on mental health of the elderly, comprised of representatives from concerned Federal agencies, national organizations, Congress, and the Judiciary, and private citizens to study, evaluate, and recommend a comprehensive set of policies for the Federal government, the several States, and local communities to pursue in this vital area.

RECOMMENDATION IX--Protection of Individual Rights

Congress should appoint a nationwide interdisciplinary committee to determine the scope and type of intervention procedures and protective services that would clearly protect the rights of the individual with health, mental health, and emotional problems requiring care. The rights of his immediate family and other close associates should be considered. This committee should include representatives of the religious, civil rights, civil liberties, legal, health and social services communities. Congress should appropiate sufficient funds to assure an indepth study of all aspects of the individual's rights in relation to his needs for health services and the administration of his affairs until he can resume responsibility.

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Intervention procedures and protective services also should assure elderly individuals their rights of self-determination in their use of health facilities and services.

In order to promote and encourage the establishment of ombudsman services, the nationwide interdisciplinary committee, or other suitable means, should be used to study and define the functions and roles of ombudsmen as separate and distinct, conceptually and in practice, from other protective services and from consumer participation in health and other matters affecting the elderly. Subsequent promotion of ombudsman services should include financial support for their activities, as well as programs to assure that their functions and findings are given full visibility at local, State, and national levels, and in both the public and private sectors.

the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on
Recreation, Leisure and Physical Fitness

MCR-35

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

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White House Conference on Aging Staff

NATIONAL RECREATION AND PARK ASSOCIATION
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Recreation

INTRODUCTION

The National Recreation and Park Association is a private non-profit organization concerned with the enhancement of leisure and recreation experiences for all people. In pursuit of this mission, the Association convened a White House Conference on Aging Mini Conference at the NRPA Headquarters in Arlington, Virginia, on January 30, 1981.

This report addresses the concerns of the aged and aging. While the Mini Conference was designed to develop recommendations in the areas of recreation, leisure, and physical fitness, the final recommendations encompass a broad spectrum of issues.

WHO WERE THE DELEGATES

The delegates to the NRPA Mini Conference on Recreation, Leisure and Physical Fitness came from various segments of the aged and aging service delivery system. They included government officials, educators, activity coordinators, public and private agency representatives, students and therapeutic recreation specialists.

HOW THE RECOMMENDATIONS WERE DEVELOPED

The delegates met in Arlington, Virginia, for a one-day conference. Briefings were delivered by the Mini Conference Co-Chairpersons, Dr. Janet MacLean, Director, Center on Aging and Aged, Indiana University, Bloomington and Dr. Fred Humphrey, Chairman, Department of Recreation, University of Maryland, College Park. An overview of the WHCoA was given by Mr. Leon Harper, Associate Director, White House Conference on Aging.

WORK SESSIONS: Delegates were assigned to one of three groups based upon their area of expertise. Each group was responsible for developing recommendations specifically related to recreation, leisure, physical fitness and the WHCoA areas of concern.

ORGANIZATION OF THE REPORT

NRPA's Mini Conference recommendations comprise the first section and are organized under the specified WHCoA categories. The narrative report was developed from position papers presented at the Mini Conference.

RECOMMENDATIONS

Research and Training

*Federal funds for research, training and demonstration should be appropriated in the areas of recreation, leisure and physical fitness relating to the aging.

*Each institution of higher learning should be encouraged to focus some of the general education requirements on the aging process and the role of leisure in the retirement years.

*The public school system should undertake a comprehensive program to emphasize the aging process in grades one through twelve.

*High priority should be given to the recruitment and training of older Americans for recreation leadership roles.

*Evaluation and assessment of current and existing programs should be undertaken to determine the most cost-efficient and effective leisure, recreation and physical fitness approaches for older Americans, and to promote such programs through national public information sources.

*Federal funds for research should be used to determine the effectiveness of media, publicity, news and information referral systems concerning older Americans.

*Research concerning the recreation and leisure behavior of older Americans' needs should be undertaken utilizing longitudinal methods to determine better control for life-stage and cohort or generational effects.

*Research should be undertaken concerning methods of modifying recreation and leisure activities, facilities and equipment to determine ways which make them more appropriate for older Americans.

*The National Institute on Aging's information system should be expanded to include all known resources to maximize all available documentation on aging.

*Research should be undertaken to determine the disincentives of social security requirements and disability regulations on remunerative and volunteer work of older Americans which may impede their participation in leisure experiences.

PHYSICAL AND MENTAL HEALTH

*Education and information programs should be designed to inform older Americans of the role of physical activities in preventative health care.

*Agencies and organizations should be encouraged to identify strategies to generate participation in physical fitness programs.

Older Americans in a Changing Economy

*Older Americans who participate in organized fitness programs and show evidence of improvement or health maintenance should be allowed tax credits.

*More effective interagency cooperation and linkages among Federal, private, voluntary and related agencies should be developed to reduce costs for the elderly.

Retirement

*The National Recreation and Park Association and related organizations, with the assistance of the Federal government, should assume the leadership in the development of a national policy on retirement, leisure and physical fitness.

Older Americans as a Growing National Resource

*Programs for developing leadership and leisure skills among older Americans should be encouraged.

*Leisure service agencies should provide technical assistance and supportive services to older adults who wish to plan and provide their own leisure programs.

Housing and Physical Environment

*Congregate housing project regulations should include provision for broad leisure opportunities BEFORE implementation of the development.

*All new technological methods should be explored to determine their potential benefits to our aging society.

Social and Health Aspects of Long Term Care

*Nutrition and health care programs for the homebound elderly should be expanded to include recreation, leisure and fitness services to enhance and maintain the physical, social and psychological well-being of the elderly.

These services should be supervised and directed by leisure service personnel and offered through interdisciplinary outreach programs organized at the local level. Whenever possible these services should involve older adult workers.

*Leisure experiences should be recognized as a viable strategy for reducing health care cost.

*Therapeutic recreation should be specified as a rehabilitation service under Medicare and Medicaid.

Family, Social Services, and Other Supportive Systems

*Leisure service personnel should be encouraged to interact with agencies whose area of responsibility has an impact on the capability of older persons to enjoy leisure experience, i.e., transportation, housing, health care, employment.

*The 1981 White House Conference on Aging should support the role of recreation, leisure and physical fitness as a significant component in the lifestyle of the elderly., Leisure services should be mandated as an integral part of the State aging plans.

*In designing and building new facilities and transportation systems, special consideration should be given to the accessibility needs of the elderly.

*Public leisure facilities and services should be re-oriented to meet the expressed needs of the elderly.

Governmental Structures for the Aging

*A position should be established within the Administration on Aging and State Office on Aging to provide a strong coordinated effort of recreation, leisure programming and physical fitness for the older adult.

*States should be encouraged to initiate or broaden senior centers to become the focal point for delivery of services to the elderly.

*The Federal Government should offer tax incentives to private industry for the development and implementation of programs directed at aging adults (especially in the area of leisure, recreation and fitness).

Special Issues Facing Minorities

*Significant improvements in income, health, housing, and education should be made for minority aging individuals so that these groups will be better able to engage in pre-retirement and retirement roles and activities, including use of leisure time.

*Better planning for leisure needs of the minority aged should be encouraged based upon their expressed desires.

*Natural focal points of service delivery should be used to publicize programs for the rural elderly.

*Well-known citizens and older citizens in rural communities should be used in the planning and implementation of leisure experiences.

*Mobile recreation centers and roving activity coordinators should be used when programming needs permit.

ARE YOU PLANNING ON LIVING THE REST OF YOUR LIFE?

The Importance of a Leisure Lifestyle to Morale in Old Age

It is generally agreed that the effective use of discretionary time by older adults is germane to their morale and psychological well-being. Were we to look at old age from a role perspective, it should be noted that the leisure role has the potential for expansion. This is in contrast to life's other roles, such as those pertaining to work and family. Yet currently the reality of being old with "time on one's hands" is often a feeling of alienation and uselessness. Older Americans have not learned "to leisure."

Good morale is conceived as encompassing the following: being comfortable with one's own aging; feeling emotionally secure and stable; being content with present life; and, having a sense of belonging to the surrounding community and society. One's leisure lifestyle can promote good morale in a variety of ways.

We can first conceptualize this lifestyle in terms of time, specifically, in the sense of defining time as having the potential for leisure and recreation experiences, and as having a future orientation. The older adult may be so firmly entrenched in the work ethic that, even in the absence of work, there is a negative perception of the value of leisure experiences. If one's perception of time has no future component, then certain activities and leisure endeavors may not be attempted because of the time required for their learning and mastery. A person may hesitate to commit energy and resources if it is felt that the lifespan is drawing to its conclusion. Leisure programs for older persons, then, should be effective in dealing with basic attitudes about the use of increased free time for self-expression and life satisfaction.

A second lifestyle component concerns leisure experiences. Too often social researchers have focused solely upon particular activities rather than activity patterns and the human relationships that may be characterized by independent, corresponding, and interactive leisure activity patterns. Each pattern requires variation in how much one interacts with others. All things considered, older people need a combination of these patterns; a time for seclusion and recuperation, as well as for intense contact with others. Leisure programs, then, should be multifocused enough to meet these various activity pattern needs. Non-participation is often linked to stereotyping of needs, interests, and capabilities of older Americans.

The third component is the preferences older people have for utilizing their time. Are older adults doing what they want? And, are their preferences corresponding to what they are actually doing? Viable leisure programs are those which attend to what the consumer aspires to do with time.

A final component is leisure satisfaction. An important psychological consideration is the general feeling of competence that older Americans have in their leisure and recreation. Are leisure programs evaluating the outcomes of their activities, such as satisfaction? The previous components of a leisure lifestyle may be reflected in one's sense that somehow time is being used in a life-enhancing fashion.

It is suggested that a leisure lifestyle, as reflected in time, experiences, preferences and satisfaction, is germane to adding life to the later years. Further, it is suggested that those leisure programs which attend to these varying, yet interrelated, facets of time use will promote good morale in old age.

THE ELDERLY, LEISURE AND FITNESS: A FUTURE PERSPECTIVE

The growing number of older adults in this country requires change in a number of societal structures and attitudes currently present in many national policies. Among the changes necessary is the value of leisure to life quality in later years. A second is the value of physical fitness in maintaining the independence of older adults. Presently, governmental funding agencies and policies at all levels do not give enough support to critical examination of these activities and their value to older consumers.

Therefore, the Older Americans Act should be revised to provide high priority funding for the critical evaluation of leisure experiences to the well-being of older persons. The Rehabilitation Act should also be amended to provide for recreation experiences in the rehabilitation maintenance and or social-psychological adjustment of the frail elderly. Additionally, the Social Security Act should include greater emphasis on preventive health measures as well as health maintenance and social-psychological functioning.

Agencies for research, development and programming should place high priority on the close examination of physical fitness of older adults, the programs used to obtain physical fitness and the competence of professionals who conduct fitness activities for the elderly. Questions which should be asked include: Does physical exercise improve the functional independence of older adults? Are all programs of physical exercise beneficial? What criteria are used to judge the effectiveness of exercise for older citizens? Can sustained physical exercise reduce the cost of health care to older adults? What effect does exercise have upon the psychological well-being of older adults? What qualifications does a program leader need before implementing and leading an exercise program? What liabilities are incurred by agencies when an exercise program is created?

Response to these issues have profound repercussions on public agencies and the older individuals they serve. Unless these two problems are addressed now, the life quality of older adults in the next century is diminished. Further, leisure service agencies may not serve to their maximum ability without proper answers to the questions proposed in this document.

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The 1981 White House Conference on Aging

Report of the Mini-Conference on Self Help and Senior Advocacy

MCR-36

UNITY IN ACTION

Betterment for United Seniors, Inc.

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"Senior citizens don't want pity, and we won't settle for being the passive recipients of elaborate charities. Our taxes and our work made this country affluent. But society tells us when we reach a certain age we don't have what it takes anymore. Self-help groups are one answer to that mythology, and our records prove it. Seniors have the skills, the energy, and the determination to deal with our own problems. We know our needs better than anyone, and we should have a say in how those needs are met. Self-help groups reach down not only to our economic needs, but to what we are, and what we can do. These groups recognize our value, our dignity, and our strength when we stick together--and that is something priceless."

--Faith Loveless, Issue Chair
Betterment for United Seniors

INTRODUCTION

Retirement is supposed to provide a period of relaxation for our older Americans, but all too often, retirement results in a host of problems for the elderly. Financial resources disappear through inflation and inadequate pensions; health care needs increase; and transportation needs become paramount. Those seniors who were poor remain poor, while those who were not poor become poor fast, as their financial resources disappear through the ever-increasing cost of living. Lack of adequate medical care and transportation, limited financial resources and fear of crime are only a few of the problems that take a toll on the lives of senior citizens.

Seniors have worked all their lives to achieve health, dignity and specific skills. Self-help groups believe that the best way for seniors to maintain these accomplishments is for them to remain active in striving for unity with other seniors to gain control of their own lives and improve the lives of others. The participants in the Mini-White House Conference on Aging for Self-Help and Senior Advocacy groups have a long history of success in developing local solutions to many of these senior problems. These self-help groups involve more than specific accomplishments. Through these groups, seniors can invest themselves in the issues that affect their own lives. The success or failure of these self-help organizations depends on senior efforts, senior skills, and senior power. By working with these self-help groups, seniors who might otherwise by isolated from the mainstream of social action continue to be part of their communities.

A United Way Agency

These groups provide an opportunity for seniors to develop needed skills; to meet and discuss their problems with community leaders; and to gain an understanding of the structure of their local government in order to function more effectively in the world around them.

Many of the problems of the elderly being discussed at the Federal level are being worked on at the local level by these groups. Self-help groups can provide much insight into these problems by sharing what they have done at a local level, and by suggesting what could be done nationally to address the difficult problems of aging.

We do not present our local successes to show that self-help groups can "do the job" instead of government, nor to have our minor successes used by the Federal government as an excuse to abandon its responsibility to the aged. We recognize that Federal programs for the aged have expanded over the years and that we now face a time of fiscal restraint. We recognize the changing role of the Federal government in the lives of all the citizens. We believe that Federal governmental programs have expanded so much partially because state and local governments, and privated institutions have not shared in the responsibility of assuring all people a fair and adequate income and service level. We also believe that many governmental programs are misconceived and focus on the results of poor planning. For example, hospital and nursing home costs to the government are extremely high. Many seniors, however, do not need these expensive programs, and could manage were some support given for preventive health care and home health care. Changing the focus of such programs could result in financial savings in the long haul, and increased independence for seniors. The work of self-help groups often focuses on these gaps and inequities in Federal programs. Our recommendations reflect our concern for preserving the independence and dignity of the older person.

FORMATION OF NATIONAL COALITION

One of the most exciting results of this mini-conference is the formation of the National Coalition of Senior Advocacy Groups. Because many of the problems our members face originate at a national policy level, and cannot be addressed by local efforts, we have established this coalition to continue working together on the national concerns brought up at the conference. These groups have a broad-based senior citizen board of directors that is representative of the elderly population served in the community and that is the ultimate policy-maker within the organization. Most are private, non-profit, independent local organizations. The issue agenda of the groups is primarily aimed at demonstrating how older Americans can help themselves; the use of senior citizens as advocates for their own concerns; and the needs of the low-income elderly. We believe that this coalition will enable us to work together to address concerns larger than any one local group can tackle.

ISSUE WORKSHOPS AND RECOMMENDATIONS

Nine workshops were held at the mini-conference, focusing on the major issues of concern to the seniors of the self-help groups. Three concerned health care: Medicare/Medicaid; Preventive Health; and Long-Term Care and Institutional Alternatives. The results of the first two will be combined in this report under "Health Care." The other workshops included Energy; Legal Aid; Housing; Crime Prevention; Transportation; and Income Maintenance.

HEALTH CARE

As people age, they become increasingly aware of their health. Chronic conditions affect most elderly people, and need constant attention and treatment. Acute illness and hospitalization affect less than 10 percent of the elderly population at any one time, and yet, most of the publicly financed and private health services attend to acute illnesses and ignore the necessity of preventive care and treatment of chronic conditions. This erroneous focus creates fragmented, often inaccessible, and sometime incomprehensible health care delivery systems that often fail to meet many of the needs of the people it is supposed to serve.

The first major problem in the health system for seniors is this focus on institutionalized care for acute illness. The second is the high price of receiving medical attention--part of this high price results from misconceptions of seniors' needs. The third problem is a lack of awareness of the special needs of the elderly in health care, reflected in the lack of geriatric specialities in medical schools and in community health services.

Many self-help groups have attempted to fill in the gaps present in America's health care delivery systems. Groups have worked for wider accessibility of generic drugs to lower the cost of the life-giving drugs. Older Americans Coalition in Delaware; the New Jersey Federation of Senior Citizens; the Metro Seniors in Action in Chicago; the Colorado Congress of Senior Organizations; and Betterment for United Seniors in Maryland have all met with varying success on the generic drug issue. Further, the Minnesota Senior Federation created its own pharmacy; and the Massachusetts Association of Older Americans negotiated a 10 percent discount with pharmacies. Both the New Jersey Federation and Betterment for United Seniors worked to create pharmacy assistance programs for low-income people, working with the states to subsidize the high cost of drugs for those who need them.

Because Medicare provides little coverage for many preventive services, some groups have attempted to fill in these gaps with their own programs. Betterment for United Seniors has created their own eye care program, negotiated with area ophthalmologists and opticians, and has worked out a dental program between a county and private dentists to provide dental care on a sliding fee scale. The Minnesota Federation has created ten low-cost health programs for their members, each negotiated with the providers of the service, including eye, dental, foot, chiropractic, and hearing aids.

Self-help groups have also tackled the problem of the lack of geriatric care and the lack of preventive treatment for seniors. The Senior Citizens' Coalition in Cleveland has won hospital outpatient reforms for seniors; Chicago's Metro Seniors in Action has worked with the Hill-Burton Act to assure care for low-income seniors; the Minnesota Federation has negotiated health care packages with both hospitals and the HMOs operating in that state. Further, Maryland's BUS gained a Senior Health Center to provide the essential type of treatment and atmosphere for the elderly; and SCC in Cleveland is now working to set up an extensive senior clinic.

Although these self-help initiatives assist seniors in certain areas of the country, they must be seen as local attempts to correct gaps of health care in the nation. Some of them could easily have national implications--strong generic drug laws; pharmacy assistance for seniors; preventive care for eye, dental, podiatry care.

BUT THERE ARE LIMITS to what local attempts can accomplish. The basic problems first stated still exist. We therefore offer these

Recommendations

On Medicare:

* Increase Medicare benefit levels to doctors to reflect more current rates, and then make Medicare assignments by physicians to Medicare mandatory.

* Permit Medicare to enter into per capita financial arrangements with HMOs, whether or not Federally qualified, and other providers in return for the provider (HMO) assuming full risk for all of Medicare coverage.

* Broaden Medicare coverage to include preventive measures such as: home health care; out of hospital prescription medication; routine eye exams; eyeglasses; hearing aids; dental care; immunizations; chiropractic; podiatry; ambulance costs; and catastrophic hospitalization.

On Geriatrics:

* HHS should use its financial leverage to get medical schools to establish geriatric medicine curriculums, including internships in long-term care facilities; and offer incentives to medical students to make the study of geriatrics more rewarding.

* Community health facilities which receive federal funding should provide specialized geriatric care.

* The National Health Service Corps should define the elderly as a medically underserved population and develop a program for recruiting doctors to serve seniors.

LONG TERM CARE AND INSTITUTIONAL ALTERNATIVES

The abuses and deficiencies in the nursing home industry are well documented and widely known. Self-help groups constantly work to provide better conditions for those elderly that truly need long term care. Institutionalized care should provide the best, most humane care with every effort to preserve all the independence and dignity inherent in each individual. Many people, however, wind up in nursing homes because there are no viable alternatives.

Home health care is everywhere preferred to an institutional setting. Yet programs and funding for home health care are nearly non-existent because the emphasis of insurance policies is on institutionalized care.

Many self-help groups have set up ombudsman and patient advocate programs and resident councils, including Elder Guild, Pennsylvania; Coalition of Advocates for the Rights of the Infirm Elderly in Philadelphia; Minnesota Senior Federation; New Jersey Federation; Metro Seniors in Action; Colorado Congress; Nursing Home Residents' Advisory Council in Minnesota; and BUS. BUS set up a local inspection process through counties rather than Maryland to check on patient care; United Seniors in Action in Indianapolis monitors the licensing of nursing homes.

BUT THERE ARE LIMITS to what local attempts can accomplish. We therefore offer the following

Recommendations

* The expansion of Medicare and Medicaid programs to include reimbursement of all home care services, including that supplied by a family member or an independent attendant.

* Tax credit programs for families taking care of the elderly.

* Implementation of the Patients' Rights Regulations, and prohibition of discrimination of patients due to financial status.

* Increased programs for sheltered housing, senior day care, and home health services.

* Maintenance of inspection of nursing homes for certification and the enforcement of regulations; better accountability of nursing home expenditures.

* Increase the personal needs allowance of medical assistance recipients and include a cost of living percentage.

ENERGY

Energy costs are one of the prime factors in pushing up the inflation rate, with seemingly no end in sight. Senior citizens are hard-pressed to counter this ever-increasing cost. Decisions about energy policy and prices are made by the interests that have most to gain by keeping prices high.

Self-help groups have been working to make their voices heard. Many have intervened in utility rate cases in gas, electricity, phone, and water rate decisions, including the Minnesota Seniors Federation; New Jersey Federation; Concerned Seniors of Dade County; Chicago Metro Seniors in Action; and BUS. Others have won major reforms in shut-off policies, notably Senior Citizens' Coalition in Cleveland and Chicago Metro Seniors in Action. Still others have worked for conservation policies such as lifeline, peak load pricing, inverted rate structure, and increased weatherization programs.

Still, the major policy decisions reflect a trend toward deregulation, centralization of energy supplies in the hands of a few companies, and alternative energy research controlled by those same interests.

The major Federal initiative to cope with the hardship of rising energy costs on the poor is the Home Energy Assistance Program, funded through the windfall profits tax. Self-help groups are working hard to make sure this program reaches those people in dire need. Even this program merely returns to the poor a fraction of costs that they have paid out in higher energy bills.

THERE ARE LIMITS to what local self-help groups can do. We therefore offer the following

Recommendations

On the Home Energy Assistance Program:

- The program must be maintained and increased, and the windfall profits tax preserved.
- Income eligibility requirements should be raised; more advertising; more local outreach.
- Applications should be processed by August to avoid delay of funds; people in government subsidized housing should be eligible.

On the Department of Energy:

- Initiate national legislation to stop shut-offs from November through April; recommend abolishing estimated billing.
- Regulate all energy sources; no deregulation of natural gas.
- Establish consumer-controlled state regulatory commissions.

On Conservation:

* Should be a major part of national energy policy. Incentives for conservation such as lifeline and removal of declining block rates should be priorities for state action.

* State energy plans should include weatherization programs and conservation measures.

On the Federal Energy Regulatory Commission:

* Hearings should be held locally on every rate increase proposed by a gas supplier, with local publicity.

* Estimated rate refund accounts should be abolished; the funds should be rebated directly to the consumers in check form.

LEGAL AID

Senior citizens often require legal assistance in drawing up wills; pension and benefit disputes; housing problems, etc. Legal services for the elderly provides this expertise, and must be maintained and expanded. Grey Law in Los Angeles is one example of the comprehensive service and advocacy role legal services for the elderly provides. BUS worked to have a Senior Legal Center set up in Maryland. Many other areas of the country are in need of these services.

THERE ARE LIMITS to what local groups can do. We therefore offer

Recommendations

* Amend the Older Americans Act to provide for a separate source of funds for Legal Services to the Elderly; seek out and encourage more private funding sources to assist in support; develop and encourage alternative sources of legal service delivery, such as law schools, national, state and local Bar Associations, volunteers, etc., to include greater private funds.

* Law schools and other paralegal programs develop programs that offer tuition-free legal and paralegal degrees to seniors 55 and over; and that these trained seniors be required to volunteer their legal services to the elderly in their communities.

* All Legal Services providers to lobby for elderly rights by amending all Federal laws and regulations that prohibit such lobbying on their behalf.

* Once a senior qualifies for Federal benefits, that decision be a final one with no periodic re-evaluation.

* Encourage the concept of/provide opportunities for seniors to work with and on behalf of them; amend DVSA to provide funding.

HOUSING

As people grow older, they can face a multitude of problems in meeting their housing needs. Homeowners are subject to heavy property taxes, and often need some assistance to maintain their home. Older people should stay in their homes and their neighborhoods whenever possible. This is often made difficult because of mounting property taxes, redlining, real estate solicitation and crime radically change the poorer neighborhoods where seniors tend to reside.

Renters are faced with deteriorating neighborhoods and frequent rent increases, conversions to condominiums which they cannot afford, or razing of the building for "progress," leaving them with no where to go.

Subsidized housing is often a last resort for low-income elderly, since the private housing market maintains fewer and fewer low and middle income apartments. Subsidized housing often puts a hidden strain on the elderly, robbing them of their confidence to speak out about housing problems in the building for fear of eviction.

Self-help groups have worked on a number of aspects of the housing problem. BUS set up a system of rebates based on property tax payments for both homeowners and renters; Cleveland worked to improve security and maintenance of public housing and stopped the urban displacement of seniors from neighborhoods in which they had been living for fifty years; Minnesota Federation set up a grant/loan program for housing repairs; Massachusetts increased Section 8 allotments and increased rehabilitation funds; the Maine Committee on Aging urged congregate housing and implemented tax and rent refunds. Metro Seniors in Action worked on condo conversion and fair rents.

BUT THERE ARE LIMITS to what local action can accomplish. We therefore offer the following

Recommendations

* Federal legislation should mandate that current occupants have statutory tenancy rights in all proposed condominium and cooperative conversions.

* Discourage the concept of relocation programs.

* All housing officials should personally participate in and investigate issues relating to housing problems of the tenants.

* Between HUD and HHS, incentives should be provided to expand the existing rent subsidies; increase support services; provide for home modification; provide multi-purpose facilities; provide funds for low-income elderly through public, nonprofit and private resources.

* HUD should, where and when appropriate, provide for adequate 24-hour security in housing for the elderly.

CRIME PREVENTION

Crime against the elderly is a problem everywhere--robberies, muggings, rape, etc. Local groups have tried to draw attention to the problem and get something done about it. Both Dade County and Cleveland seniors have been able to set up a separate police unit for seniors. Cleveland and Chicago have senior decoy units and patrols at banks and senior sites; BUS has established a foot and scooter patrol for areas with a high concentration of seniors. Improvements in housing security, victim assistantce and keeping separate statistics on elderly crime have also been initiatives of self-help groups.

Special units of police; keeping separate statistics; and escort services are all possible short-term efforts against the problem of crime against seniors. Longer term solutions might include more foot patrol; better police deployment; emergency number improvement; and stronger plea bargaining laws.

Crime seems to be an integral part of life in America, and local groups are often stymied in their efforts to address the problem.

THERE ARE LIMITS to what local self-help groups can do. We therefore offer the following

Recommendations

* Impress upon the Federal government that crime against the elderly is considered a social problem of highest priority and we demand the immediate formulation of a positive program to eliminate it.

* Because crime againstthe elderly has a direct relation to youth unemployment, we resolve to support a full employment program.

* Call upon the Federal government to increase the levels of funding for various national programs which provide resources to the elderly in their efforts to organize and speak for and defend themselves, including community anti-crime groups and block watch clubs, ACTION/VISTA, LEAA, CSA, AOA, and victim assistance programs, elderly abuse, and research.

* We need national handgun laws to protect seniors from attack.

* We also second those proposals by the National Council on Aging: police departments and volunteers should sponsor crime prevention seminars on an age-integrated neighborhood basis; escort systems should be developed; liasion groups between elderly and youth should be established to seek involvement in crime prevention programs; neighborhood-based crime programs should be developed on an intergenerational basis.

TRANSPORTATION

Transportation remains one of the major problems facing the elderly. Less mobility and less money accompany advancing age. It becomes increasingly difficult for seniors to walk to bus stops and wait long periods of time; it is also increasingly difficult for seniors to operate and maintain automobiles.

Public transportation is geared to the needs of the younger working population--to get downtown and back home. Seniors for the most part need to get around their neighborhoods to doctors/shopping.

Social service transportation is usually operated very inefficiently and only for specific agency programs. Overlapping and competing programs do not serve the needs of seniors wishing to be independent in their neighborhoods; they channel seniors into agency plans.

Self-help groups have helped make fare reductions on public transportation for seniors across the country; Dade County and Cleveland have established Dial-A-Ride systems. Public transportation has been expanded in specific instances to accommodate seniors and the handicapped in Chicago, Maryland, and Minnesota. Special senior buses have also been established in some jurisdictions, as in Maryland.

BUT THERE ARE LIMITS to what local self-help groups can do. We therefore offer the following

Recommendations

* The Federal government mandate the coordination of all federally funded social service transportation for seniors, and that all vehicles purchased with federal funds should be made available to transport seniors during down time.

* That Federal priorities be given to the development of more effective transportation for senior citizens in rural areas.

* That the Federal government provide for local senior citizen control of federal dollars for transportation of seniors.

* That funding be increased to local transportation authorities to provide adequate paratransit for seniors.

INCOME MAINTENANCE

As older people retire, they are often faced with a drastic reduction of income. Most private pensions are very small and fixed; very few elderly have accumulated a nest egg of significant savings, and inflation and poor health can wipe them out. Social Security is in increasing jeopardy, and forced retirement remains a problem.

THERE ARE LIMITS to what local self-help groups can do about the public and private retirement income policies. We therefore offer the following

Recommendations

* On Social Security issues we recommend an adequate income for all Americans based on the higher BLS standard for a couple, with 75 percent of that for an individual; the elimination of the earnings limitation test for Social Security recipients; Social Security beneficiary participation and control on policy making Boards; no cuts in benefits and no change in COLA formula, but rather a special senior citizen consumer price index; no change in the eligibility requirements; no taxes on benefits; and a return to 100 percent disability benefits.

* On Supplemental Security Income (SSI) program, we recommend increase in the benefit level up to the BLS higher standard to treat elderly poor as equal to all older Americans; immediate end of in-kind income; increase in income resources to $5,000; elimination of "living with others" category; inclusion of Puerto Rico, the Virgin Islands and all territories; increase in personal allowances for institutionalized elderly with COLA.

* On savings issues, we recommend a $500 exemption of interest income from savings from all federal taxes; that savings account interest rates be deregulated.

* On pensions, we recommend elimination of mandatory retirement clauses from pension contracts; COLA clauses included; elimination of federal taxes on pensions with a ceiling at the BLS higher standard.

* On employment, we recommend the complete elimination of mandatory retirement; full employment with special job opportunities, training and re-training; and part-time work.

* On taxes, we recommend the immediate closing of all tax loopholes for individuals and corporations; the re-establishment of a strong progressive tax system to provide adequate revenues to fund the above and other aging programs.

SUMMARY

The Self-Help groups participating in this White House Mini-Conference are representative of the local, active, grassroots senior organizations around the country. The discussions of the issues came from the long experience participants had in tackling issues at a local and state level. Personal opinions and personal problems had little weight in the discussions. Rather, the problems and frustrations that the participants experienced in their local organization formed the basis of the recommendations presented here.

The mini-conference was less a summation of long and hard work by the local organizations--it was a beginning of a new and difficult type of work. Long isolated from one another, the conference enabled the groups to begin to form a network to tackle large national issues together in unity. While our local work will continue unabated, self-help groups have come together to address issues previously beyond our resources.

The National Coalition of Senior Advocacy Groups will afford self-help groups to become more effective by sharing resources and experience, and by confronting those problems affecting us all on a national level.

Our final recommendation would be to urge the formation of more such self-help groups, to encourage and enable senior citizens of this country to speak out for themselves on the decisions that affect their lives.

WHITE HOUSE MINI-CONFERENCE ON AGING

SELF-HELP AND SENIOR ADVOCACY

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the 1981
White House
Conference
on
Aging

Report of the Mini-Conference on Public/Voluntary Collaboration: A Partnership in contributing to independent living for the aging

MCR-37

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

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REPORT OF THE NATIONAL VOLUNTARY ORGANIZATIONS FOR INDEPENDENT LIVING FOR THE AGING (NVOILA), A PROGRAM UNIT OF THE NATIONAL COUNCIL ON THE AGING (NCOA): WHITE HOUSE CONFERENCE ON AGING MINI-CONFERENCE, "PUBLIC/VOLUNTARY COLLABORATION: A PARTNERSHIP IN CONTRIBUTING TO INDEPENDENT LIVING FOR THE AGING," (November 23-25, 1980, Washington, D.C.)

The increasing limitations on available governmental resources have given rise to the even greater necessity of examining resources available through utilization of the non-governmental sector. The following report reflects this concern. It addresses voluntary sector resources and ways to promote cooperative working relationships between the public and voluntary sectors. Such a partnership is essential to effective planning and implementation of quality services on behalf of older people.

Included in the report is the charge to mini-conference delegates, a description of NVOILA and the conference planning process, a list of conference participants, the mini-conference agenda and the final conference outcomes. The outcomes--recommendations and additional concerns--address a broad range of issues related to the development of a comprehensive, coordinated service delivery system designed to maximize options and promote independent living for older persons.

CHARGE TO THE DELEGATES

General John F. McMahon, former commander-in-chief of the Volunteers of America and current chairman of NVOILA, stated in his charge to the delegates:

"Our presence here has special meaning for NVOILA and the future of service delivery to the aging. NVOILA as a federation grew from the 1971 WHCoA, when a group of 125 national voluntary associations joined together because of their shared concern for promoting independent living for the nation's older population. NVOILA, currently with 226 member associations, serves as the voice for a large segment of the voluntary sector, which is a viable, capable resource for enhancing community-based services to the aging.

"It is fitting that we should assemble to consider critical issues that confront and challenge us. The voluntary sector has long been a capable and supportive network for older persons. The Older Americans Act mandates that area agencies on aging coordinate service to older persons by designating specific responsibilities among existing providers. Many county and city offices on aging have similar responsibilities. We shall consider these mandates and decide how most effectively to respond to them.

"We recognize the need for creation of a partnership between public agencies charged with planning and service to the aging and voluntary agencies that have served older people as part of their clientele over the years. The concept is not new. Since 1978 NVOILA has sought actively to develop and implement a national strategy for increased public/voluntary collaboration.

"At the same time, we are aware also of the need to maximize the effectiveness of services and to reduce the costs of delivering them. The key to success lies in cooperation and in the uniquely diverse composition of the voluntary sector. Collaborative efforts by public and voluntary organizations--as both achieve better understanding of each other's resources and capabilities--can increase and improve services for older persons in general and the more vulnerable elderly in particular.

"You, as mini-conference delegates, have a difficult and complex task. Your recommendations will be channeled to technical committees, to state meetings and to national WHCoA delegates when they convene in November-December 1981. Your actions here will form the springboard for significant future results."

WHAT IS NVOILA?

National Voluntry Organizations for Independent Living for the Aging (NVOILA) is composed of 226 national voluntary organizations. The member organizations share a common interest and commitment to promote and contribute to the right to dignity, comfort and self-determination of older persons. NVOILA's purpose is to:

- increase visibility of the need for in-home and community-based health and social services designed to help older persons remain in or return to their own places of residence
- stimulate and assist national voluntary organizations to work cooperatively and through their local affiliates to help develop such services
- serve as an advocate for more effective private and public services designed to help vulnerable older persons live independently
- work with the appropriate public sector structures to bring about a creative public/voluntary partnership in these program areas

- provide a forum for national organizations, agencies of government and consumers to express their ideas and develop an effective network of services for the aged

NVOILA's membership includes service delivery organizations; professional organizations, and organizations categorized as civic, fraternal and denominational. Membership is open to any national voluntary organization, agency or group sharing the concern that more options be available in every community to enable adults to maintain a maximum level of independence.

Since early 1979, NVOILA has been involved in the planning to provide the voluntary sector's perspective to the 1981 White House Conference on Aging (WHCoA).

In addition to this mini-conference, NVOILA's WHCoA Task Force on Continuum of Services has prepared an issue paper for use in the WHCoA process. A Directory of National Voluntary Organizations, indicating the voluntary sector's capacity to serve the aging, will also be utilized by the WHCoA as a guide for delegates to gain understanding of the roles the voluntary sector can play in service to the aging.

PLANNING AND STRUCTURE OF THE NCOA/NVOILA WHCoA MINI-CONFERENCE

In June 1980, NVOILA's membership voted to sponsor a WHCoA Mini-conference with public/voluntary sector collaboration and cooperation as its theme.

The NVOILA Executive Committee authorized the NVOILA WHCoA Advisory Committee to plan conference specifics. The following topic areas were identified for discussion and development of recommendations by conference delegates:

1. What are the characteristics of public/voluntary relationships at the community level now? There was discussion of the present conditions of cooperation between voluntary associations and public agencies at the local level and recommendations were formulated for both the public and voluntary sectors for enhancing the effectiveness of collaborative efforts.

2. What are voluntary associations doing now to promote and contribute to independent living for older Americans? Discussion focused on the strengths and capabilities of voluntary associations for serving older Americans at both the national and local levels. The workshop sections were divided by the type of organization each delegate represented:
    1. a national association representing local civic, fraternal, community service, denominational associations;
    2. a national association representing a particular profession;
    3. a national association representing direct service providers.

Recommendations which will strengthen involvement in services that contribute to independent living for older Americans were formed for each of the three categories of national voluntary associations.

3. What is the voluntary sector's role in health maintenance and promotion for the homebound elderly? Recommendations for the "public aging network" to effectively utilize the voluntary sector in these roles were developed.

4. What are the roles of the public and voluntary sectors in protective services? How do protective service needs differ for older persons living independently as opposed to those institutionalized or those living in a private residence with others? Recommendations for the public sector to effectively utilize the the voluntary sector in protective services were made.

5. What are the public/voluntary sector roles in strengthening the informal network? Recommendations were formulated for both the public and voluntary sectors.

6. What can the public and voluntary sectors do to stimulate creative independent living arrangements? What should be the voluntary sector roles in developing and sponsoring creative living arrangements for older persons?

The leadership of each of NVOILA's member national voluntary associations and public sector agencies from the national, state and local levels was invited to designate delegates. The goal of delegate selection was to convene a WHCoA Mini-conference with a broad yet balanced perspective representing many types of voluntary associations as well as governmental agencies at all levels concerned with older Americans.

The conference format was designed to assure the greatest possible opportunities for delegate participation in identifying specific issues and translating them into recommendations. All recommendations were fully formulated during the scheduled workshops.

All delegates preselected the topics of interest to them and were assigned to particular workshops. The workshop topics corresponded to conference topics described earlier.

The following conference activities assisted delegates in carrying out their charge by touching off meaningful dialogue in workshops and, subsequently, the formulation of substantive recommendations.

- Dr. Ellen Winston, Deputy Chairperson of the WHCoA and President of The National Council on the Aging (NCOA), in a presentation entitled, "Now is the Time for Voluntary Initiative: Our Impact on the 1981 WHCoA Process," spoke about the necessity and value of public/voluntary cooperation, as well as the role of this mini-conference in the total WHCoA process.

- Edward F. Howard, J.D., General Counsel, NCOA, discussed "Federal Laws and Regulations: Barriers or Channels for the Non-governmental Sector in Contributing to Independent Living for Older Americans." He provided information on legislation affecting independent living and the voluntary sector, as well as the past relationship of the Federal government with the nongovernmental sector. In addition, Mr. Howard made some projections concerning the changing political environment and possible implications for the voluntary sector.

- The final pre-workshop activity was an interaction presented by Mr. Glenn Allison, Special Assistant to the Executive Director, National Association of Social Workers, representing the voluntary sector and Ms. Jeanne Bacon, Director, Mid-American Regional Council, representing the public sector. This discussion was useful in clarifying the realities of trying to promote public/voluntary cooperation. Both presentations advocated the need to continue to make this a priority effort.

The first working day of the conference (Monday, November 24) was allocated to discussion of the two larger topics:

1. What are the characteristics of present public/voluntary relationships at the community level?
2. What are voluntary associations doing to promote and contribute to independent living for older Americans?

Two sessions of each of the more specific topic areas, described earlier, were run on Monday evening and Tuesday morning to allow delegates to attend two of the four.

Conference recommendations were adopted at the closing luncheon on Tuesday, November 25, 1980. Jack Ossofsky, NCOA Executive Director, provided the closing luncheon presentation. He encouraged continued and expanded efforts of the voluntary sector as we strive to achieve the right to dignity, comfort and self-determination for older persons.

OUTCOMES OF THE CONFERENCE: RECOMMENDATIONS

The following recommendations are the result of the workshops on the two larger topic areas noted earlier. As described, one group was assigned to examine the strengths and capabilities of voluntary associations for serving older Americans. However, in addition to this assignment, participants felt compelled to address the topic assigned to the other workshop; cooperation with the public sector and a means to enhance that relationship in order to develop a service system responsive to the needs of older persons. This serves to emphasize the overriding importance of the concept.

RECOMMENDATION: That a communitywide planning and coordination process for all health and social services be carried out by a locally designated community body; that this process include consumers, representatives of planning agencies, voluntary, private, non-profit and public sector providers and representatives from all funding sources.

RECOMMENDATION: That Federal, state and local eligibility regulations across programs be made compatible; that geographic boundaries for all public social services and health planning and service areas for all programming coincide. Eligibility requirements should be based on the individual demonstrated need for services.

RECOMMENDATION: That the policy advisory structure at the state and local levels established under the Older Americans Act require representation of the voluntary sector involved with providing services to the aging.

RECOMMENDATION: To enhance the quality of life, to enable older adults to live independently and to protect their right of choice, we recommend a "continuum of services" system for each community supported by a national policy that assures a comprehensive, coordinated system of services. All components of the system must be available, accessible and acceptable to all who need them. Older adults must be included in the planning, providing and evaluating of such services. Achieving this goal for each community is a joint public/voluntary responsibility.

We call upon the White House Conference on Aging to affirm the value of voluntary organizations in all communities. Voluntary organzations should be encouraged to form coalitions and/or other forms of cooperative relationships with the public sector; to assess the unmet needs of older adults; to recommend the establishment of comprehensive programs and to monitor and evaluate these programs on a continuing basis.

RECOMMENDATION: We recommend that the White House Conference on Aging encourage opportunities for the training of volunteers as an essential part of the programs of the public and voluntary sectors, keeping in mind the following goals:

- that training be made accessible to all regardless of age,race, income and/or geographical locale
- that volunteers be further enabled to provide appropriate direct services, advocacy and serve as catalysts for social change
- that funding for the costs of this training (materials, instructions, facilities, etc.) be provided by voluntary, private and governmental agencies

RECOMMENDATION: To ensure delivery of services of high quality, we recommend the enactment of Federal legislation requiring national professional and provider associations to develop standards of practice, providing for education and training to both promote the standards and monitor their implementation. The standard-setting process should include both consumer participation and appropriate local adaptation.

To promote independent living for the aged, a formal mechanism should be established at state and local levels to assure coordination of programs among voluntary organizations and public agencies. The mechanism should be implemented through existing programs, such as NVOILA.

The primary goal of such coordination is to facilitate cooperation in planning the following areas:

- access to and utilization of services
- education of service providers, public agencies and service recipients
- delivery of services
- research, including but not limited to needs identification, methods of service delivery and evaluation
- utilization of available funds
- identification of needed supplementary funds

Delegates were called upon to formulate recommendations in the area of health promotion and maintenance for the homebound elderly. They were asked to give specific attention to activities the public sector and others can realistically expect the voluntary sector to perform and/or participate in.

RECOMMENDATION: The development of a national policy on health promotion, well-being and maintenance for older adults as an integral component of the continuum of services system. This policy should reflect the need for:

- social, behavioral and bio-medical research
- a clearinghouse of research information
- economic consideration, i.e., the development of third party reimbursements and funding services designed to promote social and life support services

RECOMMENDATION: That the staff of provider organizations, while delivering services to older people, be sensitive to evidence of need for preventive and other services. Organizations with established facilities and expertise (in health maintenance and physical fitness) for younger age groups are encouraged to support this effort.

Furthermore, all services provided by the voluntary sector should be delivered with an awareness and consideration of health promotion and health maintenance of the older adults served.

RECOMMENDATION: The voluntary sector should develop a partnership among health providers, consumer organizations and older consumers to foster understanding and development of holistic health promotion and health maintenance for well-being in later life, including:

- a multidisciplinary approach for more effective linkage between lay and professional organizations
- introduction of education about the aging process into the curricula of schools for all age levels
- a new or enlarged emphasis on physical and mental health inthe curricula of educational institutions for the health professions and in the training programs for other health service providers.

The following recommendations address the topic of protective services for older persons and the roles public, voluntary and informal networks may play in their delivery.

RECOMMENDATION: That every state develop and provide a legislative base for the provision of protective services to older persons to be drafted in consultation with knowledgeable practitioners in the public and private sectors. Legislation features should include, though not be limited to, the following:

- provision of a basis for assessing need for intervention and, once determined, for regular re-assessment to determine if intervention continues to be necessary
- provision of a range of intervening actions designed to respond to individual needs
- continuation of supportive services, including those provided by the voluntary sector
- requirements for mandatory reporting of elder abuse with proper safeguards for the informant
- recognition and support of families that assume responsibility for care of older members
- development of an ombudsman process to guard against abuses by protective service agencies
- provision of training for staff and volunteers in assessing needs for delivery of protective services

RECOMMENDATION: That a public agency such as the Administration on Aging (AoA), or a private organization such as NCOA, form a national committee on protective services for older persons to assess the state of the art, to propose national policy, to make and develop proposals on programming and funding--and further, that state units, area agencies on aging and other appropriate groups lead a collaborative effort at state and local levels to mobilize the resources of voluntary agencies plus the various professions and volunteers who serve older Americans needing protective services.

The informal support service network is unique in its service capabilities and in the support required to strengthen its efforts. Informal supports include family, friends, colleagues, social, civic, cultural, religious affiliations, neighborhoods and self-help groups. The next three recommendations provide ideas about what the voluntary and public sectors should do to support and strengthen the informal network.

RECOMMENDATION: That public policy at all levels recognize, endorse and protect the integrity of informal support groups serving the elderly regardless of economic status; that policies be examined to identify barriers to effective working relationships between the public/voluntary systems and the informal networks, and steps be taken to remove the barriers.

RECOMMENDATION: That the informal service network be strengthened and supported by providing needed information, resource materials and technical assistance; that incentives for informal supports to offer their resources on behalf of older people, through such means as tax deductions, financial assistance and other supports to services (home care, day care, respite care, etc.), be provided.

RECOMMENDATION: That training about the significance of informal networks and how they operate be included in both in-service and pre-service programs for professionals, volunteers and informal network groups, with emphasis on the interface between the public/voluntary sectors and informal networks.

The discussion on means to stimulate creative independent living arrangements for older persons resulted in two recommendations which address roles for both the public and voluntary sectors.

RECOMMENDATION: That the voluntary sector take a leadership role in raising public consciousness and in providing information on the multiple options for small group and other housing arrangements by:

1) effecting a coalition in the public and private sectors for compiling and disseminating information accessible to all interested persons
2) affording continuing education to volunteers, professionals, older people and other interested persons on housing options available to the older adult.

RECOMMENDATION: That public policy should provide incentives toward development of and participation in small group living arrangements through:

1) direct funding through a) loans for rehabilitation and new housing and b) expansion of Medicare/Medcaid services
2) financial incentives such as tax deductions to assist families maintaining elderly parents in their homes
3) removal of barriers such as restrictive zoning, unrealistic licensing and conflicting program requirements

ADDITIONAL CONCERNS

There were several cross-cutting concerns and recommendations which emerged in the various workshop sessions. Though the areas are not necessarily reflected in the final conference recommendations, they should be considered an important element of the conference proceedings.

- Governmental policy, regulations and practice at the local level often disregard the potential capabilities, actual experience, programs and resources of voluntary agencies and volunteers. Given this, there must be identification and definition of resources, roles and responsibilities within both the public and voluntary sectors. The reality of implementing the public/voluntary cooperation concept brings to the surface problems common in any effort to integrate and/or collaborate; e.g. turf, balance of power, visibility, administration, etc. Each sector should be organized to maximize its effectiveness and to assure representation of both sectors in decision-making processes.

- Attention must be given to broadening the number of options for older people and their participation in decision-making processes that affect their lives. Older adults are a resource to the service delivery network and should be recognized and utilized as such.

- Long-term care policy must coordinate the efforts of both the voluntary and public sectors while including informal or natural supports. The total needs of the older person and a holistic approach to service delivery should be of concern to any agency or individual providing service.

  In accordance with the above, a "continuum of services" system should be established, including preventive, diagnostic, therapeutic, rehabilitative, supportive and maintenance health and social services. The system should also include informal, community and professional support under public, private and voluntary auspices and offer services on both a formal and informal basis.

- There is a need for a mechanism through which state and local voluntary associations can coordinate their activities as well as support and educate one another in serving older Americans.

Additional concerns and recommendations also emerged related to the following specific topic areas:

Health Maintenance and Promotion

- Aging cannot and should not be automatically equated with frailty and illness. Maintenance of independent living can be enhanced through a range of interventions resulting from collaborative efforts of the public and voluntary sectors.

- The goal in health maintenance and promotion for older people should be to make them responsible for their own health through e.g., active health education programming.

Protective Services

- There is a wide range of responsibilities the voluntary sector can assume in the area of protective services, including: provision of support services, staff training, material development, outreach, counseling and coordination of efforts with governmental agencies.

Stimulating Creative Independent Living Arrangements

- It is necessary to assess preferences of older people in terms of living arrangements and to inventory the range of available options. Options must be assessed for adequacy and information about them disseminated to interested persons. We must experiment with new creative arrangements in order to expand alternatives, paying particular attention to group home arrangements.

CONCLUSIONS

The voluntary sector has shown repeatedly its ability to initiate and supplement services that contribute to independent living for the aging and that its resources can be mobilized to serve frail older persons in both rural and urban communities. By providing transportation services, telephone reassurance, friendly visitors, educational, informational and other necessary services, local voluntary groups have made important contributions to the welfare of older persons. Many have demonstrated a willingness and ability to cooperate effectively with the public sector to plan and implement services.

At the 1979 NCOA annual conference in Cincinnati, Ohio, Dr. Ellen Winston, NCOA president, past NVOILA chairperson and deputy chairperson of the 1981 WHCoA, noted the following:

"Public/voluntary collaboration does not just happen, nor can regulations alone bring about effective cooperation. The key is leadership. Such leadership can come from the public or voluntary sector--at the national, state or local level. It can come from within an agency or organization seeking closer working relationships with other agencies or from the outside. At any rate, someone or some group has to take the lead to develop a coordinated service delivery system or even coordination of a single service.

It takes strong leadership to counteract vested interests, resistance to change, misunderstandings and even suspicions of motives, fear of standards and just plain ignorance ofother agencies, their programs and of other possible ways of providing services. These barriers are found in both the public and voluntary sectors. We must create a climate of approval for the agency that works cooperatively with other agencies in the community and provide any technical assistance needed in the development of new patterns of operation..."

CONFERENCE PARTCIPANTS

The following governmental agencies representing national, state and local levels participated in the mini-conference:

ACTION
Administration on Aging
Boston Commission of Affairs for the Elderly
Department of Community Affairs, Recreation Division
Federal Council on Aging
Florida Department of Health and Rehabilitative Services
Georgia Department of Health and Human Resources
Massachusetts Department of Elder Affairs
Montgomery County (Maryland) Council on Aging
Miami Valley (Ohio) Council on Aging, Inc.
Mid-American Regional Council
New York State Office on Aging
Oklahoma Commission for Human Services
Retired Senior Volunteer Program (R.S.V.P.)
Social Security Administration
South Carolina Commission on Aging
U.S. Department of Education, Office of Special Education and Rehabilitative Services
U.S. Department of Agriculture, SEA Extension Services
U.S. Department of Housing and Urban Development
U.S. House of Representatives Select Committee on Aging
Virginia Office on Aging
White House Conference on Aging

The following national voluntary organizations were participants in the mini-conference process:

Adult Education Association of the United States of America
Amalgamated Clothing and Textile Workers Union
American Academy of Physicians' Assistants
American Alliance for Health, Physical Education, Recreation and Dance
American Association of Colleges and Junior Colleges
American Association of Homes for the Aging
American Association of Opthalmology
American Association of University Women
American Association of Workers for the Blind
American Baptist Churches
American College of Nursing Home Administrators
American Council of the Blind
American Dietetic Association
American Federation of Teachers
A.F.L.-C.I.O.
American Geriatrics Society
American Health Care Association
American Health Planning Association
American Home Economics Association

American Hospital Association
American Legion
American Library Association
American Lung Association
American Lutheran Church
American Medical Association
American Medical Association Auxiliary, Inc.
American Mothers' Committee, Inc.
American Nurses' Association
American Occupational Therapy Association, Inc.
American Optometric Association
American Pharmaceutical Association
American Protestant Hospital Association
American Psychological Association
American Red Cross
American Society for Geriatric Denistry
American Speech-Language-Hearing Association
Amyotrophic Lateral Sclerosis Association
Arrow, Inc.
Asociacion Nacional Pro Personas Mayores
Association of Junior Leagues, Inc.
Association of Ladies of Charity of the United States of America
Black Caucus of Health Workers
Blue Cross and Blue Shield Associations
B'nai B'rith International
B'nai B'rith Women
Catholic Golden Age
Catholic Health Association
Civic Action Institute
Council of Jewish Federations
Episcopal Society for Ministry on Aging
Evangelical Covenant Church of America, Board of Benevolence
Family Service Association of America
Future Homemakers of America
General Federation of Women's Clubs
Green Thumb
Leadership Conference of Women Religious of the United States of America
Lutheran Church in America
Lutheran Church/Missouri Synod
Lutheran Resources Commission
National Association of Area Agencies on Aging
National Association of Home Health Agencies
National Association of Social Workers
National Association of State Units on Aging
National Board of YMCAs
National Cancer Foundation
National Capital Medical Foundation
National Center on Ministry with the Aging
National Conference of Catholic Charities
National Council of Catholic Women
National Council of Community Mental Health Centers
National Council of Health Centers

National Council of Jewish Women
National Council on Family Relations
National Easter Seal Society
National Educational Association
National Extension Homemakers' Council
National HomeCaring Council
National Indian Council on Aging
National Institute of Senior Centers
National Interfaith Coalition on Aging
National Jewish Welfare Board
National Pharmaceutical Council
National Recreation and Park Association
National Retired Teachers' Association/American Association of Retired Persons
National Safety Council
Pilot Club International
Salvation Army
United Church of Christ, Board of Homeland Ministries
United Methodist Church, Board of Discipleship
United Neighborhood Centers of America
United States Catholic Conference
United Way of America
Urban Elderly Coalition
Veterans of World War One of the United States of America, Inc.
Volunteers of America
Zonta International

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REPORT OF

MINI CONFERENCE ON GERONTOLOGICAL NURSING

for the

WHITE HOUSE CONFERENCE ON AGING

CLEVELAND CLINIC

Cleveland, Ohio
March 27-29, 1981

Sponsored by: The American Nurses' Association, the Cleveland Clinic Foundation and Upjohn Health Care Services.

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Nursing Conference
on
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I'm in the old age group now, so I can speak as an old person. What I want most from the health care system is to help me maintain my functional state. When I say functional state I mean mental, physical, social and spiritual. I want to maintain my functional state at the highest level possible. I don't want to lose my mind; I don't want to lose my ability to walk around. What can you do to help me to maintain my functional state? It's very simple. I think in order for you to do this as a nurse you have to be well-prepared in nursing of older people. That way you can offer me indepth health services.

Testimonial by an older person.

HIGHLIGHTS

In order to serve today's needs and tomorrow's challenges, positive action must be initiated now by and on behalf of America's older adult population. Our nation's older people deserve quality health care. We believe nurses in gerontological practice can make a positive difference (ANA, 1980).

The national goal for healthy older adults as stated in the Surgeon General's report *Healthy People* (1979) is "to improve the health and quality of life for older adults and, by 1990, to reduce the average annual number of days of restricted activity due to acute and chronic conditions by 20 percent, to fewer than 30 days per year for people aged 65 and older". The objective of nursing is to assist older adults in the management of the complex nature of their health care needs. The Committee of Nurses for the White House Conference on Aging is convinced, however, that this objective cannot be achieved in the absence of strong policies from the public and private sector that will support and encourage less costly alternatives to institutional care presently required by older Americans. The trend of an increasing older population demands a greater utilization of a broad range of health care services, provided by nursing personnel which includes registered and licensed practical nurses and nurses aides. Particular attention should be given to policies which would enhance innovative changes in reimbursement for services and an extension of noninstitutional services. These changes would permit the consumer to choose the services and providers that would best meet individual health care needs.

Within the broad context of a national commitment to care for the health needs of our older population, the committee prioritized the following recommendations:

1. *Government and private sector should provide for reimbursement for health education, health promotion and disease prevention and should allow the consumer to choose services and providers.* Nurses as providers of health services offer a broad range of services such as nursing care, health needs assessment, health teaching, counseling, planning, coordination and evaluation for the effectiveness of these services for older adults in non-institutional and institutional settings. These services should be reimbursable through third party payment. The redistribution of the health care dollar is needed to emphasize health promotion and disease prevention among older adults. Health services should focus on the attainment and maintenance of a balance of one's physical, mental, social and spiritual well-being and not merely on attaining improved control of diseases or infirmity. Every older adult has the right to strive or be assisted in striving to achieve maximum health potential. The nurse is uniquely prepared to assist the older adult in achieving and maintaining a level of wellness consistent with the

limitations imposed by the aging process, acute and/or chronic illness.

2. The government and private sector should work together to provide financial support for educational opportunities to prepare nurses in the care of the older adult. Based on the projected increase of the aged population and the roles of nurses, it is estimated that a large increase in registered nurses and licensed practical nurses will be needed to provide adequate nursing care in all settings where older adults seek services. Financial support should be committed to prepare faculty teaching gerontological nursing. Innovative educational approaches to encourage recruitment and retention of nurses caring for the elderly should be the financial priority of government and the private sector. Providing funds, for example, for a gerontological nursing learning center where health in aging can be studied would have a positive impact on the understanding of incontinence, confusion, senile dementia, and reactions to medications. Studies of the delivery of services would be significant to an understanding of appropriate designs of long-term care, home health care, and self-care.

3. The government and private sector should pursue policies that would encourage the development and implementation of care provided by nurses based on creative concepts of wellness. Providing creative alternatives for health care for older adults will assist them in improving their health and well being through the active exercise of their responsibility for decision making. Alternatives may include "well adult" clinics, self-care clinics, and living arrangements which are based on a philosophy of wellness, self-care, and disease prevention. These concepts can be integrated into the community health nursing system and into established senior and adult day care centers. The nurse provides the guidance, skill, information, encouragement and sense of value, in assisting the older adult in living to the fullest possible extent. The preservation of self-determination in all aspects of living, including health care, is essential to achieving a high quality of life.

4. The government and private sector should give priority to and provide support for nursing research which would address the major health issues of older adults. Nursing research of health and illness related to aging will have a significant impact on improving the quality of life in later years. Government and the private sector should commit funding to nursing studies to determine what are the most creative, cost effective and cost-beneficial models of health care services delivery. Nursing research conducted in an experimental, teaching nursing home, for example, would provide new knowledge in the treatment of acute and chronic illness, decubitis ulcers, arthritis, incontinence, confusion, and senile dementia. This center would enable nurse researchers to study such

services as hospice care, "nursing homes without walls", care of the long-term patient in acute care settings and primary health care as outreach services which include primary health care in nursing homes.

SUMMARY

INTRODUCTION

The number of Americans reaching old age is the most dramatic demographic change of the twentieth century. Associated with this fast growth have been changes in the social, economic and health care structures of our society, particularly those aspects that affect the elderly. Older adults as a group use health resources to a greater extent than any other age group. Despite the increasing outlays from the Federal budget for health, income and community services for those over 65 years of age, health needs continue to go unmet. The demand for services, particularly a broad range of health care services, will only continue to increase with the growth of this population.

The national goal for healthy older adults as stated in Healthy People is "to improve the health and quality of life for older adults and, by 1990, to reduce the average annual number of days of restricted activity due to acute and chronic conditions by 20 percent, to fewer than 30 days per year for people aged 65 and older." The objective of nursing is to assist older adults in the management of the complex nature of their health care needs. We are convinced, however, that this objective cannot be achieved in the absence of strong policies from the public and private sector that will support and encourage less costly alternatives to institutional care. Strategies to meet this objective include third-party reimbursement for wellness care, health promotion and disease prevention provided by nurses, financial support for the education of nurses, and support for nursing research which would address the major health issues of older adults.

OBJECTIVES OF THE COMMITTEE

In the last few years, particular attention has been focused on the issue of long-term care: availability, quality, cost and appropriateness of the long-term care health services received. Health care reimbursement that overemphasizes institutional care while restricting the use of nonmedical community support services has led to inadequate and inappropriate care of the elderly. Considerable responsibility for older adults and their responses to the aging process belongs to the service provider. Nurses, as health care providers, are consistently involved with older adults, because the components of care they are prepared to provide assist in managing daily living as it is affected by fluctuations in health and illness.

To provide services to meet the older adult's health care needs requires a commitment of both providers and policy makers alike. Such a commitment is essential to examining the status of the health care delivery system as it presently exists and to effect constructive changes in policies governing health care provisions for older adults. Policy changes are essential if the goal of healthy older adults is to be achieved. The objective of the conference participants was to develop various strategies that would address the diverse and complex issues of health care delivery to present and future generations of older adults. While discussion led to numerous recommendations, the following strategies to achieve the goal of healthy older adults are essential:

1. The provision for reimbursement for health promotion and disease prevention, allowing the choice of those services and providers that would support older adults in achieving and maintaining their maximum health potential.

2. Educational opportunities to assist nurses in developing the attitudes, knowledge and skills necessary in providing quality health care services to older adults.

3. Policies directed toward creative concepts of wellness care provided by nurses that would promote and sustain health and permit older adults to remain functional and lessen the threat of premature or unnecessary institutionalization.

4. Support for nursing research of health and illness issues related to aging that would significantly and positively impact on improving the quality of life for older adults.

METHOD

In 1980 the American Nurses' Association Division on Gerontological Nursing Practice appointed its Task Force on the White House Conference on Aging. It is one of the goals of the Task Force to develop statements on current trends in gerontological nursing and issues related to delivery of health care services to older adults. To achieve this goal the Task Force published its first statement Gerontological Nursing: The Positive Difference in Health Care for Older Adults.

The Chief Nurse of the Public Health Service perceived a need to convene a nursing conference on the White House Conference on Aging. The purpose of the conference was to prepare a document that would identify the profession of nursing's position on health care of older adults.

Arrangements for the conference were organized through the Cleveland Office on Aging. Funding was provided by the American Nurses' Association, the Cleveland Clinic Foundation, and Upjohn Health Care Services. Drafts of the issues identified and developed by the ANA Task Force formed the basis for the organization of the conference. The deliberations of the group resulted in the prioritized recommendations as identified in this report.

Participants of the conference included members of the ANA Division on Gerontological Nursing Practice and the Task Force on the White House Conference on Aging, licensed practical nurses represented by the National Federation of Licensed Practical Nurses, representatives of Upjohn Health Care Services, and the Office of the Chief Nurse, U.S. Public Health Service.

CONCLUSIONS

The participants of the nursing conference concluded that it is the objective of nursing to assist older adults in the management of their health care needs. We believe each American ought to be able to expect good health care for the whole of a lifetime -- however many years that may be. Health services should focus on the attainment and maintenance of a balance of one's physical, mental, social, and spiritual well-being and not merely on attaining improved control of diseases or infirmity. Every older adult has the right to strive or be assisted in striving to achieve an independent and rewarding life in old age unlimited by many health problems that are within his or her capacity to control.

The trend of an increasing older population, particularly those beyond age seventy-five, will place a greater demand on services for those limited in function due to chronic illnesses. Current policies for eligibility, reimbursement, and delivery systems impose on this population acute and institutional care. The family dimension is the least recognized, but most important element in planning a system to meet the health care needs of older adults. The unique characteristics of older adults and their caring families points up the need not only for specific policies and methods of service delivery, but also for special educational programs and research by nurses caring for older adults.

The Committee on Nurses for the White House Conference on Aging is convinced, however, that these objectives cannot be achieved in the absence of strong policies that will support and encourage changes in reimbursement policies, the preparation of nurses in the care of older adults, creative concepts of wellness, and nursing research which addresses the major health issues of older adults.

Within the broad context of a national commitment to healthy older adults we specifically conclude that:

Recommendation #1

Government and private sector should provide for reimbursement for health promotion and disease prevention and should allow the consumer to choose services and providers. Nurses as providers of health services offer a broad range of services such as provision of services, health needs assessment, health education, counseling, planning, coordination and evaluation for the effectiveness of these services for older adults in non-institutional and institutional settings. These services should be reimbursable through third party payment.

It is the goal of older adults to seek to maintain their optimum functional capabilities in the least restrictive setting possible at an affordable cost. The redistribution of the health care dollar that emphasizes health promotion and disease prevention would assist the older adult in achieving that goal. Health services should focus on the attainment and maintenance of a balance of one's physical, mental, social and spiritual well-being and not merely on attaining improved diagnosis and treatment of diseases or infirmity. Every older adult has the right to strive or be assisted in striving to achieve their maximum potential. Quality health care services which would include health promotion and disease prevention should be available to older adults regardless of sex, race, or economic status. These services should be:

- delivered in the appropriate setting
- at the appropriate time
- with regard for the dignity and the choice of the individual
- within a framework which guarantees coordination among all levels of care, and continuity of care over time
- efficient and effective in assuring reasonable costs.

The nurse is uniquely prepared to assist the older adult in achieving and maintaining a level of wellness consistent with the limitations which may be imposed by the aging process and acute or chronic illness. Studies have indicated that there are, and will continue to be, increasing requirements for nurses to provide acceptable and accessible health care services in this country.

As the complexity of health care increases, the demands for nursing services and personnel increase. These personnel must be prepared to meet the complexities of health promotion and health maintenance in a variety of settings.

In addressing these needs, policy makers must recognize the implications of the critical shortage in the supply of nurses that presently exists and its impact on health care service delivery to older adults. Efforts to encourage the recruitment of males and minorities, Hispanic, Black, Pacific Asians, American Indian, would increase the quantity of available human resources to deliver services.

Effective utilization of nursing personnel consistent with their level of preparation and experience is essential. The status of nurses in gerontological settings must be enhanced if nurses are to recognize the positive contribution that may be made in these settings. Salaries, benefits and working conditions must be competitive with those received by nurses in other settings.

Recommendation #2

The government and private sector should work together to provide financial support for educational opportunities to prepare nurses in the care of older adults. Presently, large numbers of nurses providing services to older adults have not had formal preparation or experience in gerontological nursing. A 1976 survey of schools of nursing by the American Nurses' Association revealed that 94% of the faculty were self-taught in the care of older adults, with other faculty reporting attendance at workshops (72%) or continuing education courses (61%). The population trends, particularly the rapid growth of the over-75 elderly, emphasize the critical need to prepare nurse faculty and practitioners to provide knowledgeable and quality care to older adults and their families.

The new insights gained on senile dementia and the potential reversibility of this condition could have a dramatic impact on reducing the numbers of older persons hospitalized or placed in long-term-care settings with this condition. The nurse prepared to incorporate expanding knowledge of the aging process into the practice setting would contribute significantly to the quality of life and the reduction in public costs of over-utilization and inappropriate use of institutional services.

Innovative changes in governmental (federal, state, and local) support of health services for the elderly should include a percentage of the reimbursement to be earmarked to finance educational programs for nurses caring for older adults. The Health Care Financing Administration, for example, should provide financial support for gerontological nursing education. Likewise, the participation of gerontological nurse practitioners in primary health care for the elderly has been recognized as enhancing patient access to services, decreasing costs, and providing a broader range of services. Thus, policy makers should support the preparation of gerontological nurse practitioners to provide primary health care through their preparation in nursing diagnosis, clinical judgment and management abilities to restore, Maintain, and improve the health status of older adults.

The largest number of care givers in long-term care settings are registered nurses, licensed practical nurses and nurses' aides, who may or may not have the benefit of formal preparation in the care of older adults. Government and the private sector should recognize the need to prepare registered nurses and licensed practical nurses to supervise, manage and train nurses' aides.

RECOMMENDATION #3

The government and private sector should pursue policies that would encourage the development and implementation of creative concepts of care provided by nurses based on wellness. Providing creative alternatives in health care for older adults will assist them in improving their health and well-being through the active exercise of their responsibility for decision making. Alternatives may include "well adult" clinics, self-care clinics, and living arrangements which are based on a philosophy of wellness and self-care. These concepts can be integrated into the community health nursing system and into established senior and adult day care centers. The promotion of wellness and self-care responds to the emerging recognition of the importance of independent living and broadens the range of options and resources available. Providing incentives and reimbursement practices that would allow for care in the home and other noninstitutional settings would reduce the problem of unnecessary institutionalization as well as provide a broader and better range of services in the appropriate setting. Health promotion marketing strategies must be expanded to include the education of consumers and health and providers regarding the aging process and health care options with particular emphasis on health and wellness throughout all stages of life.

The nurse provides the guidance, skill, information, encouragement, and sense of value in assisting the older adult in living to the fullest extent possible. It is the contribution of nursing to support the older adult and family in achieving a high quality of life, an acceptable life-style pattern and control over his/her life. To achieve these goals, the preservation of self-determination in choosing which services are best suited to the individual and family and where these services can be obtained most appropriately is essential.

RECOMMENDATION #4

The government and private sector should give priority to and provide support for nursing research which would address the major health issues of older adults. Research in aging has made significant advances in understanding processes of aging and the treatment of some of the disabling effects of aging. Nurses as the largest professional group providing health care to older adults should be given top priority for funding nursing research to further advance knowledge and practice. Older adults and their families would benefit significantly from nursing research studies of self-care, health maintenance, quality of life in chronic illness, functional abilities, and hospice care. Tremendous savings of private and public dollars as well as personal and family expenditures for long-term care would be realized by nursing research studies of three major causes of institutionalization: incontinence, confusion, senile dementia.

The rapidly increasing ethnic and minority populations deserve particular attention of nurse researchers to develop the knowledge base of these population health needs.

It is well-documented that 80% of care to older adults is given by family members or neighbors and friends of the family. Studies of how nurses can best support, educate, and counsel these care-providers is essential to discussion of policies which would provide financial reimbursement to family care-givers.

We believe that these broad recommendations represent sound health strategy within which to develop the detailed policies and programs for both government and the private sector. This positive action initiated now will make a positive difference in the health care of older adults.

BACKGROUND

Introduction

Implementation of these recommendations are based on the growing national concern for quality of life and health in the later years and changing demographics. It is reasonable to expect that by the year 2020, one out of every five American citizens will be over sixty-five years of age, with a large proportion of this group being over 75.

Data from epidemiological studies indicate that if we are to have a responsible health care system, we must accurately measure health care needs and problems. For a number of years, lack of knowledge about the origins of chronic diseases barred us from developing preventive strategies. This is no longer true. Victory over today's major killers--heart disease, cancer, stroke--must be achieved more by prevention than cure. Likewise, we have to be able to take into account the high incidence and prevalence of disorders which accumulate in the later years--senile dementia, arthritis, incontinence.

Further support of the recommendations is based on cost. The pattern of a highly technological, acute treatment approach of health care for older adults is costly not only in terms of federal dollars but in "out-of-pocket" expenses of older adults themselves. Unless the present system is changed these costs will become only more unmanageable.

With these considerations in mind, background information in support of the recommendations is developed in the following report.

Recommendation #1

Government and the private sector should provide for reimbursement for health promotion and disease prevention and should allow the consumer to choose services and providers. A major theme for the 1980's will be redesigning national health policies and programs for older adults. The ability to provide good health care for the fastest growing segment of the population is a concern of health professionals, policymakers and their older constituents. The urgency of this concern is emphasized by the high cost of acute and long-term health care services received by only eleven percent of the U.S. population. If demographic experts are correct in their analysis of an increasingly older population, these health care costs will soar in the present health care delivery system. Although it is alarming that persons over 65 receive, per capita, the highest proportion of public financing for health care, the average Medicare beneficiary is paying more "out-of-pocket" for health care today than before the program went into effect (NCHS, 1977).

Our greatest difficulty may be less a matter of costs than of beliefs about how and where health care should be given. The problem of providing good health care for older adults is complicated by the bias in the U.S. health care organization and financing toward acute, inpatient, curative, and high-technology care at the expense of primary, preventive, and appropriate long-term care. The older population certainly suffers from acute illnesses, but their major health difficulties are largely chronic and relate to a decline in functional capacity. Thus, most older adults are more likely to need assistance in caring for themselves in everyday situations. These are primarily individuals with some functional dependency--the inability to attend to personal care, such as ambulation, eating, hygiene, shopping, dressing, laundry, meal preparation, paying bills, or social activities--that need not result in medical intervention or institutionalization. As Eisdorfor (1981) states, "In our conscious desire to preserve life we have ignored the needs of the living".

Current policies of eligibility for reimbursable health services focus on disease and illness. Physician reimbursement and education are linked to technology, that is, more sophisticated detection of disease. Likewise, a deep-rooted belief exists that hospitals and institutional settings are the best way to provide health care. Physicians trained in the acute institutional model fail to recognize the value of alternative community services which may delay or prevent institutionalization.

Thus, a trend toward the medicalization of problems of aging has emerged, and this pattern has had consequences that ignore opportunities for health promotion and disease prevention for older adults. The older adult must demonstrate an illness or the need for medical care prior to receiving any non-medical services. These reimbursement policies also restrict access of older persons to health professionals who are educationally prepared to provide health promotion measures to prevent disease and functional dependency. Although it is the goal of older adults to maintain their optimal functional capabilities in the least restrictive setting possible, and at an affordable cost, few older adults have the opportunity to exercise the freedom of choice of either services or providers.

There is much the government and the private sector should do to assist older adults in achieving healthier old age and to function as independently as possible. Health promotion, health maintenance and disease prevention programs would permit older adults to seek an independent and rewarding life in old age, unlimited by many health problems that are within their capacity to control (Surgeon General's Report, Healthy People, p. 71). It is essential that a redistribution of the health care dollar occurs that would provide a redirection of emphasis to health promotion, health maintenance and disease prevention. Such change in focus would:

- assist the older adult in achieving his/her goal;
- facilitate the development of appropriate and adequate services in preparation for older age;
- recognize the ability of older adults to determine the services of which they are in need;
- permit the older adult to exercise his freedom of choice of both services and providers of those services.

Health services should focus on the attainment and maintenance of a balance of one's physical, mental, social, and spiritual well being. It should not be limited to merely attaining improved control of diseases or infirmity. Every older adult has the right to strive or be assisted in striving to achieve their maximum potential. The present health care delivery system provides support for expensive acute phases of illness. Quality health care services which would include health promotion, health maintenance, and disease prevention should be available to older adults regardless of sex, race or economic status. These services should be delivered:

- in the appropriate setting
- at the appropriate time
- with regard for the dignity and the choice of the individual
- within a framework which guarantees coordination among all levels of care, and continuity of care over time
- efficiently and effectively in assuring reasonable costs

Reimbursement policies should permit consumers of health care direct access to nursing care services. The nurse is uniquely prepared to assist the older adult in achieving and maintaining a level of wellness consistent with the limitations which may be imposed by the aging process and/or chronic illness. Nurses as providers of health services offer a broad range of services such as nursing care, health needs assessment, health education, counseling, planning, coordination and evaluation for the effectiveness of these services for older adults in non-institutional and institutional settings. These services should be reimbursable through third-party payment. The World Health Organization in its Position Paper on Health Care of the Elderly: The Role of Nursing has recommended that:

"Nurses be the primary health care workers, responsible for

> providing comprehensive care for groups of elderly and families and that these caring services should be integrated into the general health care system" (WHO, 1980).

Studies have indicated that there are, and will continue to be, increasing requirements for nurses to provide acceptable and accessible health care services in this country. As the complexity of health care increases, the demands for nursing services and personnel increase. These personnel must be prepared to meet the complexities of health promotion, health maintenance, and disease prevention in a variety of settings. In addressing these needs, policy makers must recognize the implications of the critical shortage in the supply of nurses to care for older adults that presently exists and its impact on health care service delivery to older adults. Efforts to encourage the recruitment of males and minorities, Hispanic, Black, Pacific Asians, American Indian, would increase the quantity of available human resources to deliver services. Effective utilization of nursing personnel consistent with their level of preparation and experience is essential. The status of nurses in gerontological settings must be enhanced if nurses are to recognize the positive contributions that may be made in these settings. Salary benefits and working conditions must be competitive with those received by nurses in other settings. The achievement of professional self-determination in nursing practice would maximize their delivery of health care services to older adults. Only in addressing all of the intricate and complex issues of the shortage in the supply of nurses will a positive outcome be realized.

Recommendation #2

Government and private sector should work together to provide financial support for educational opportunities to prepare nurses in the care of the older adult. Based on the projected increase of the aged population and the roles of nurses, it is estimated that a large increase in nurses will be needed to provide adequate nursing care in all settings where older adults seek services (AOA, 1980). As health care spending for and by older adults has increased many questions have been raised about the availability, appropriateness and quality of the health services they receive.

Improvement in health services for older adults will depend primarily on the competency of the person providing the care. Thus, all nursing personnel and the non-professional groups they supervise involved in the health care of the older adults in any setting should have a background in the concepts of aging, chronic illness, fluctuations in states of wellness and disease in aging, and the consequences of medical or chemical interventions for older adults.

Presently, large numbers of nurses have not had the opportunity to gain knowledge about the aging process. A 1976 survey of schools of nursing revealed that 94% of the faculty were self-taught in the care of older adults, with other faculty reporting attendance at workshops (72%), or continuing education courses (61%) (ANA, 1977). Despite the trend of declining federal resources, the Federal government should provide financial support to prepare faculty teaching gerontological nursing. Such a program would provide a national resource and national impact on the health care of older Americans. State governments and the private sector should contribute to the preparation of nurses at the basic practice level since these programs are most often providing nursing manpower for the state and local areas.

Innovative educational approaches to encourage recruitment and retention of nurses caring for the elderly should be the financial priority of government and the private sector. The demand for registered nurses has increased especially in the field of gerontology. By 1982, it is estimated an additional 75,000 registered nurses prepared in the care of older adults will be needed for nursing homes (U.S. Dept. of HEW, 1978).

An educational program conducted nationwide by the American Nurses' Association with the support of a government contract, sheds light on the need to update knowledge and skills of nursing home nurses and may be useful for designing creative programs for recruitment and retention of nurses to care for older adults. A survey of the participants in the program indicate that preference for working with the elderly as the primary reason for working in a nursing home (ANA, 1974). As the ANA report indicates, many respondents added comments that they went into nursing home nursing not knowing what to expect. After a period of employment, however, they became increasingly enthusiastic about this area of practice. A question about formal geriatric nursing content in the participants' basic nursing programs revealed 75.6% (of 3080 participants) had not received gerontological nursing in their basic educational preparation. The most frequently identified outcome of their participation in the Educational Program was to improve nursing care and the second to understand the aging process. Educational programs could be offered as incentives for recruitment and retention of nurses in care of older adults along with other motivational factors such as salaries competive with nurses in other settings, opportunities for career advancements and convenient work schedules.

Nursing home care is only one segment of the health services older adults receive. Hospitals report that the over sixty-five population varies from 30-60% of the patient population in acute care settings. Currently, 61.4% of the estimated 987,234 practicing registered nurses are employed in acute care settings (American Nurse, 1980). The majority of nurses employed base their practice on entry-level preparation. In an unpublished survey conducted by the American Nurses' Association (1976), only 9% of the schools responding required courses in gerontological nursing; an additional 5% made courses available to interested students; of 97% of schools reporting gerontological content integrated in the basic curriculum, 59.4% indicated they spent less than 15% of classroom time on principles of care of the older adults. Thus, it is essential that government and the private sector support basic educational programs that have both didactic and clinical learning experiences in caring for older adults. Support for continuing education also in didactic and clinical care knowledge in caring for older adults should be available for nurses who were graduates of programs which had no gerontological/geriatric components.

Another strategy for providing higher levels of care specific to older adults in acute, long-term care and self-care settings would be expanded use of gerontological nurse specialists (GNSs) and gerontological nurse practitioners (GNPs).(3) Utilization of these professionals has been particularly lacking in nursing homes and community care settings. Poor salary for nurses and failure to recognize the advanced preparation as a strategy to improve health care are major reasons for the underutilization of gerontological nurse specialists and practitioners. Gerontological nurse specialists engage in a number of activities which relate to the care of older adults. More specifically, characteristic functions of specialists include:

- Identification of populations or communities at risk
- Direct care of selected patients or clients, in any setting, including private practice
- Intraprofessional consultation with nurse specialists in different clinical areas and with nurses in general practice.
- Interprofessional consultation and collaboration in planning and evaluating total patient care
- Contribution to the advancement of the professional as a whole and to the speciality field (American Nurses' Association, 1980).

It has been recognized that GNPs can enhance patient access to services, decrease costs, and provide a broad range of services. Although the need for GNPs is well documented, only 459 registered nurses graduated from these programs between 1975 and 1980 (Stone, 1981). This group is uniquely prepared to make a significant impact on health care of older adults. While barriers such as reimbursement and availability of educational programs are a problem, a much greater problem is that there are too few nurses prepared as GNPs. The government and private sector should provide financial support for educational opportunities to prepare nurses in these roles.

For many of the proposals mentioned above, funds could be made available through the reimbursement mechanisms. Since nurses already function in roles providing direct health services to older adults. It is reasonable that a percentage of the reimbursement for these services be earmarked to finance educational programs for nurses. There has been much discussion of Medicare reimbursement paying for the salaries of health care workers. The government should consider closer examination of using portions of the reimbursement as resource funds for the teaching of gerontological nursing to give additional benefits to Medicare beneficiaries.

Recommendation #3

The government and private sector should pursue policies that would encourage the development and implementation of creative concepts of care provided by nurses based on wellness.
In order for each older adult to achieve maximum independence and feelings of well-being, health care must be positive--a practice based on wellness. The promotion of wellness and self-care responds to the emerging recognition of the importance of independent living for the older adult and broadens the scope of options and resources available to them. Older adults most fear dependency and loss of control over their lives through illness, disability, and the inability to care for themselves.

It is a common misconception that the majority of older adults are institutionalized. Yet this applies to only five percent of the total older population. The remainder--and majority--of older adults remain in the community either in their own homes or living with persons other than a spouse. Some of these older adults are completely independent. Their major needs are the ability to care for themselves independently. With appropriate assistance and modification of life style these older adults are able to maximize their strengths and adjust to their limitations.

If incentives and reimbursement practices would allow for non-medical service delivery in the home and other non-institutional settings, the problem of unnecessary institutionalization would be reduced. Older adults and their families prefer a broader range of services provided in appropriate settings as the need arises. Health promotion marketing strategies must be expanded to include the education of consumers and health care providers regarding the aging process and health care options with particular emphasis on health and wellness throughout all stages of life.

As an advocate, the nurse assists the older adult in formulating a balanced image of his/her wellness/illness status. This is achieved by focusing on goals rather than problems and abilities rather than disabilities, thereby assisting the older adult to adapt to living with a chronic condition (s) when present (Rober, 1980).

One major goal of gerontological nursing is the preservation of self-determination by the older adult. Providing creative alternatives in health care for older adults will assist them in improving their health and well-being through the active exercise of their responsibility for decision making. Alternatives may include "well" adult clinics, self-care clinics, and living arrangements which are based on a philosophy of wellness and self-care. These concepts can be integrated into the community health nursing system and into established senior and adult day care centers. The geriatric day hospital which provides care during daytime hours and allows return to the home in the evening presents yet another option in health care delivery.

These suggestions are consistent with the recommendations of The World Health Organization in its Position Paper on Health Care of the Elderly: The Role of Nursing:

- Creative alternatives in health care for the elderly be encouraged, such as "well elderly clinics" integrated into the community; health care services organized and run by the elderly, nurses and other health workers as requested.

- A health promotion and chronic illness prevention program be initiated and provided by nurses early in the individual's life cycle, focused on those health behaviors of one's life style that contribute significantly to the chronic conditions and major causes of death in the elderly.

- Emphasis on health and wellness throughout the various stages of the life cycle, with the goal of self care and self-help be basic to the philosophy of nursing care of the elderly and their families (WHO, 1980).

The power of health information increases the older adult's control over the outcome. The nurse provides the information needed to assist older adults in becoming knowledgeable about the availability of programs and services, potential benefits from participation in programs, potential outcomes from the utilization of services, the rights and responsibilities of users of services, and program eligibility criteria.

The design of programs utilizing creative concept of care based on wellness will enhance and support the capability of the individual, family, and other informal support systems in exercising maintaining control over all aspects of life influenced by their health status.

It is the nurse who provides the guidance, skill, information, encouragement, and sense of value in assisting the older adult in living to the fullest extent possible. It is the contribution of nursing to support the older adult and family in achieving a high quality of life, an acceptable life-style pattern and control over his/her life. To achieve these goals, the preservation of self-determination in choosing which services are best suited to

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the individual and family and where these services can be obtained most appropriately are essential.

Recommendation #4

The government and private sector should give priority to and provide support for nursing research which would address the major health issues of older adults. Research in aging has made significant advances in understanding processes of aging and the treatment of some of the disabling effects of aging. Education and recruitment of nurses with special competence in the field of aging require a complimentary activity in research related to aging. Potential areas of research in aging greatle exceed the pool of competent nurse researchers and the funds to support existing nurse researchers. Research in gerontological nursing has occurred in five substantive areas: psychosocial characteristics of older adults, patient characteristics influencing care, direct patient care, health care delivery systems, and characteristics of the caregivers of older adults (Martinson, 1980). Although the contributions of nursing research knowledge about the care of older adults has been increasing, the majority of studies focus on institutionalized, chronically ill older adults. Knowledge gained from these studies applied only to approximately 5% of older adults. Although there is much the nursing profession itself can do to prepare and promote nurse researchers-there is a contribution which must be shared by government and the private sector.

Specifically, government and private sector should provide financial support for nurses conducting studies which relate to nursing care of older adults: management of bowel and bladder incontinence, confusion, senile dementia, Alzeheimer's Disease, nutrition management, rehabilitation, to name a few examples.

Of the 2,348 doctorally-prepared nurses, 8 indicated their major area to be gerontology; another 8 had gerontological nursing as their major; and 81 indicated nursing research as their major area of study (ANA, 1980). It cannot be said at the present time that there is an existing cadre of gerontological nurse researchers but there is a nucleus of a group with the potential of building upon the research-based knowledge of caring for older adults.

There is a growing awareness that valuable resources are not infinite and their use must be carefully considered. Within this context, increasing attention is being given to the cost of health care strategies to meet the emerging needs of the nation. Thus, the goal of nurse studies is the ongoing development of knowledge for use in the practice of nursing. As a young field, gerontological nursing needs to further develop and test care strategies to:

1. ensure health care needs of older adults are being

met through appropriate practices;

2. enhance older adults' abilities to manage acute and chronic illness to minimize institutionalization and maximize wellness (Nursing Research, 1980);

3. enhance the knowledge base of culturally or ethnically difficult older adults; and

4. provide most cost-effective, cost-beneficial health care services.

The testing of health care strategies could potentially reduce the incredible national expenditures on health care, expenditures which are associated with disabilities and diseases of old age.

The government and private sector should support the establishment of model learning and research centers to specifically conduct nursing research. Establishment of a nurse-managed, teaching nursing home would provide a setting to study major problems of institutionalized older adults: incontinence, confusion, mobility, chronic illness, problems of the old-old. It would also provide a setting for investigating staff patterns, the appropriate range of services based on needs, and the potential outpatient services to older adults living in the community.

Another strategy for providing funds for gerontological nursing research would be to provide financial support for nurses seeking doctoral preparation. This would encourage nurses to focus research activities on older adults and health services delivery to this population.

Federal and local governments could also encourage investigations relating to older adults and their families by earmarking a percentage of reimbursement for their health care services to go toward gerontological nursing research.

Support of nursing research in aging is based on striking findings of available data especially on demographics. It is reasonable, based on current demographic trends, that in 2020, one out of every five American citizens will be over sixty-five years old. The health care professional of the future will be responsible for large numbers of older adults.

The second argument is an epidemiological concern. If we are to have a good, responsible health care system, we must accurately and realistically measure health care needs and problems. For example, we have to be able to take into account the high incidence and prevalence of disorders which accumulate for the first time in the later years. One of these, senile dementia-so devastating to the quality of human life-is perhaps the fifth greatest killer in the United States. Butler states senile dementia is probably the reason for at least 50% of admissions of older adults to nursing homes. This and other problems-arthritis, diabetes, heart disease-need investigation so that the health care system can respond effectively.

The third argument for support of nursing studies of the care of older adults is cost. Fifty percent of health care dollars goes for care and treatment of chronic disease. Also, data from a 1975 study indicates one-third of all acute hospital beds were occupied by older adults. Lastly, any discussion of cost must consider the costs of drugs. With one-fourth of all drugs being consumed by older adults, the cost in federal dollars and out-of-pocket expenses is nearly unmanageable. Without research to provide data, money and time saving as well as cost-saving measures cease to find a means to be incorporated.

FOOTNOTES

[1] The report of the International Conference on Primary Health Care states,

> The conference considered primary health care to be essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (WHO, 1978).

[2] Preparation at the basic levels of the registered nurse (RN), or professional nurse, can be obtained in one of three types of programs diploma (traditionally a three-year program attached to a hospital), associate degree (a two-year program most frequently found in community or junior colleges), and baccalaureate degree (usually a four-year program which is part of a college or university). Successful completion of one of these programs gives the student the right to sit for state board examinations. Successful completion of the examination confers the right to use the title, "registered nurse".

Licensed practical nurses (LPNs), in some areas are called licensed vocational nurses (LVNs), are prepared to function under the direction and supervision of a registered nurse and/or physician. The LPN is qualified for nursing practice by attending state-approved programs in community colleges, vocational schools, or hospital-affiliated programs, which vary in length from 52-78 weeks. Basic training for LPNs is standarized among states and the LPN is certified by licensure.

Nursing assistants or nursing aides may enter the system with no or varied experience in patient care, and no minimal education or experience requirements. The nursing assistant training is the responsibility of the employing agency and varies by agency in length and quality. The nursing assistant is always under the direct supervision of a professional nurse and is not singularly accountable by licensure or certification for the care which he/she provides for patients.

[3] A gerontological nurse specialist is a registered nurse prepared

at the graduate level (Masters' degree) and functions as an expert in a clinical area, i.e., in the care of older adults. Nurse practitioner refers to a registered nurse who has successfully completed a formal program of study, preparing the nurse to provide primary health care through nursing diagnosis, clinical judgement, and management abilities. This formal program may either be through graduate education in which a Master's degree is awarded or a continuing education (non-degree) program.

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the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on
Pacific Islanders Jurisdiction

MCR-39

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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March 18-19,1981

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PACIFIC AMERICAN TERRITORIES ON AGING
Mini-Conference, Guam
March 18-19, 1981

Introduction

The many groups of small islands that make up the PACIFIC AMERICAN TERRITORIES present a special challenge to the policy-makers in our nation's capital. While many of the problems of our elderly are similar to those of the elderly in the continental United States, the solutions may not be the same. Just the logistical problems encountered in trying to provide services to people living on a few hundred square miles of dry land that are scattered throughout a million square miles of ocean can be bewildering.

Added to the logistical problems, there is also a cultural distinction which demands that each problem be examined in the light of varying ethnic nuances among the peoples to be served. This might be compared to the special consideration sometimes given to the American Indians, Blacks, or other ethnic minorities. Here again, the problems are similar but different. The mainland minorities have had as long as two centuries to adjust to their minority positions. Pacific Islanders have only had 30 to 40 years to adjust to the idea of having to live by rules promulgated in a distant land and enforced by a minority representative living among us.

Similarly, the current state of development of our infrastructure is severely lacking and in many cases totally inadequate. Most of the very basic facilities which are taken for granted in the United States are hold overs from World War II. The bulk of the roads and utilities were developed for war time use and turned over to local governments for use and maintenance when the occupation forces departed. What roads there are have fallen into a sad state of disrepair.

Clinics and hospitals, which one would usually find within a very close radius of a few minutes drive, may be non-existent or attainable only after a long arduous voyage through open ocean or a long flight, if the island can support a landing strip or be reached by a medivac helicopter. Outreach programs designed to benefit the elderly at home are of necessity few and far between.

Housing programs designed to meet the needs of the average American do not necessarily fit the needs of the elderly of the PACIFIC AMERICAN TERRITORIES. Culture and heritage play a strong role in family life. Man-made events of history, such as war and colonization have forced traumatic alteration of lifestyles. The unprotected isolation of the islands makes them vulnerable to natural disasters, such as typhoons, as well as man-made disasters, such as wars.

The history of the Pacific Islanders is one of oppressed colonized people. Our needs are unique, in terms of the socio-economic development of our islands, our culture and traditions. We all share common problems such as manpower resources, community resources and technical resources, and other supportive research data. The opportunity to become involved in the planning of advocacy efforts by nationally recognized groups is rarely given. As a general practice, we have not had access in the formulation of national policies and programs. We are extremely desirous to present our concerns and to work with decision-makers in order to establish our unique needs and problems and to identify the most relevant and appropriate strategies which are responsive to our cultures, values, lifestyles and the social and political conditions under which we all live. We, the Pacific Island Peoples, are very concerned about the lack of visibility and opportunity by Pacific Islanders to influence national policy at all levels of government.

Chronological Events

To achieve a common goal by which our concerns on aging are guided into national forums and decision-making processes, it was decided at the Pacific Asian Elderly Conference on Aging in San Francisco, California, on January 15-16, 1981, that the Pacific Islanders request funding and technical assistance from the National White House Conference on Aging for the purpose of holding their own mini-conference in the Pacific Basin. Our rationale was our advocacy for our right to:

a) determine our priorities and strategies to meet those needs;

b) assure our recognition and visibility of our problems and concerns;

c) establish a network of Pacific Island resources for Pacific Island needs; and

d) establish a special concern session for Pacific Islanders at the 1981 White House Conference on Aging.

PACIFIC AMERICAN TERRITORIES ON AGING

On February 23, 1981, our request to hold a mini-conference by, with, and for the Pacific Islanders was officially sanctioned with instructions to hold it no later than the second week of March, 1981.

A pre-mini-conference was held on Saipan, Commonwealth of the Northern Marianas, on March 5-6, 1981, at which representatives from American Samoa, Commonwealth of the Northern Marianas, Guam, and the Trust Territory of the Pacific Islands met to identify common issues to be addressed at the upcoming mini-conference. A significant development of this meeting was that our delegates, in recognition of the common goals of the peoples and the strength that can be gained through unity, pledged our efforts to our mutual benefit under the new designation of "PACIFIC AMERICAN TERRITORIES ON AGING."

Mini-Conference Report

At the mini-conference in Guam on March 18-19, 1981, a resolution establishing a council of the PACIFIC AMERICAN TERRITORIES ON AGING and requesting a special concern session at the 1981 White House Conference on Aging was adopted. The issues were divided into three major categories:

I. HEALTH CARE

Lack of resources is our major problem. Our communications systems are inadequate; our telephone systems are outdated in most areas and not existing in others. In some areas, the only communication with neighboring areas is through shortwave radio. The roads as discussed earlier are poor. The isolation and distance between islands impose geographical constraints on health care programs. We also have severe shortage of proper equipment and trained and skilled personnel. National insurance programs are not applied in the territories the same as they are in the United States. In some areas where Medicaid is provided, a ceiling is imposed. While in other areas, there is no Medicaid Program at all. The Older Americans Act does not include nor support assistance for inadequate comprehensive health systems.

II. HOUSING

For generations, the extended family system has been, and still is, one of the most significant and prevalent aspect of our cultures. The concept of urbanization and institutionalization continues to force a major shift in our lifestyles. These existing practices are not attuned to our traditional customs nor conducive with our architectural prototypes.

III. TRANSPORTATION

The archipelago geography of the PACIFIC AMERICAN TERRITORIES involves the elements of air, sea and land. Poor roads and inadequate or no intra-island transportation inhibit delivery of services to the elderly. The lack of any developed public transportation systems precludes the elderly from obtaining needed services.

Closing Comments

The initial experiment in providing a forum for more local cooperation and input into the decision-making process on the national level can only be evaluated as a resounding success. In the future, more consideration should be given to the uniqueness of the problems confronting the PACIFIC AMERICAN TERRITORIES. Our rich cultural heritage often dictates novel solutions and oblique approaches to problems that are handled in some routine manner on a day-to-day basis on the national level. Hopefully, this will serve as a model and forerunner in the future.

Identifying Data

1) State: PACIFIC AMERICAN TERRITORIES
2) Date of Conference: March 18-19, 1981
3) Place of Conference: Dai Ichi Hotel, Tumon, Guam
4) Names of Persons Submitting Report:

   Judge Joaquin V.E. Manibusan, Guam
   Tali T. Maae, American Samoa
   Edward M. Cabrera, Commonwealth of the Northern Mariana Islands
   Leona I. Peterson, Trust Territory of the Pacific Islands

5) Title of Persons: State Coordinators - 1981 White House Conference on Aging

Participation

6) Total No. of Participants: 60
7) Sex: Number of Female 39
   Number of Male 21
8) Ethnicity/Race: 5% Caucasian;
   95% Pacific/Asian;
9) Handicapped: None
10) Age: 43 under 55 17 55 and over

PACIFIC AMERICAN TERRITORIES ON AGING

Summary of Issues and Recommendations

HEALTH CARE

A. Issues

The representatives of the PACIFIC AMERICAN TERRITORIES ON AGING recognize that their prevailing health systems are inadequate to provide minimal health care for the elderly. These systems are not adequately addressed by present federal legislation.

B. Policy Recommendations

1. Resolve that modification of federal legislation and attendant regulations to improve health care delivery systems so that these systems are more relevant to meet the specific needs of our elderly.
2. Resolve that the Older Americans Act and applicable regulations be clearly defined to include and support the comprehensive health systems often inadequate or absent in the respective areas of the PACIFIC AMERICAN TERRITORIES.

HOUSING

A. Issues

The geographical composition and the cultural variances of the PACIFIC AMERICAN TERRITORIES signify diverse lifestyles. Therefore, existing housing programs are not necessarily conducive to meeting the living conditions relevant to Pacific Island culture.

B. Policy Recommendations

Resolve that the Federal policy-makers be more sensitive to the traditional extended family system among Pacific Islanders, and that the island planners be given the option to formulate the best possible program to meet the elderly's needs, and to utilize and maintain the familial cultural ties.

PACIFIC AMERICAN TERRITORIES ON AGING

TRANSPORTATION

A. Issues

The widely dispersed island geography, combined with the economic condition and cultural heritage, of the PACIFIC AMERICAN TERRITORIES does not lend itself to the development of mass transit systems as developed in more industrialized communities.

B. Policy Recommendations

Resolve that special consideration be given to develop alternate modes of transportation compatible with the archipelago of the PACIFIC AMERICAN TERRITORIES.

Action Recommendations

1. Due to the unique problems and remote location of Pacific Islanders, a local organization made up of indigenous representatives would be best qualified to represent our interest. We, therefore, recommend that PACIFIC AMERICAN TERRITORIES ON AGING be nationally recognized as a distinct entity from the National Pacific Asian Elderly Research Center as representing the interests of Pacific Islanders.

2. So that a proper forum might be available on the national level for presenting our proposals, we recommend that a special concern session at the 1981 White House Conference on Aging be given to the PACIFIC AMERICAN TERRITORIES ON AGING.

3. To ensure proper recognition of Pacific Islanders' needs, we recommend that the Administration on Aging within the U.S. Department of Health and Human Services draft and forward to U.S. Congress proposed legislation that would amend the Older Americans Act to provide a special provision for the elderly of the PACIFIC AMERICAN TERRITORIES.

4. Cognizant of the prevailing attitude of the current administration regarding spending, we recommend that alternative solutions be sought regarding funding as follows:

a) Utilization of existing funding sources under the Act to provide constructive program implementation for meaningful and relevant services responsive to Pacific Island needs; and

b) That the Administration on Aging within the U.S. Department of Health and Human Services establish effective inter-agency agreements with other agencies whereby unused funds committed to a program for the elderly in one agency that is not being implemented on the local level may be transferred to another agency which could better utilize existing funding; and

c) That a member of the PACIFIC AMERICAN TERRITORIES be given first priority to apply for reallotment and use of any funds returned by a member of the PACIFIC AMERICAN TERRITORIES.

RESOLUTION NO. 81-1

ADOPTED: March 18, 1981

RELATIVE TO ESTABLISHING A COUNCIL CONSISTING OF AMERICAN SAMOA, COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS, GUAM, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS, TO BE KNOWN AS, "PACIFIC AMERICAN TERRITORIES ON AGING", TO ACHIEVE A COMMON GOAL BY WHICH CONCERNS ON AGING ARE GUIDED INTO NATIONAL FORUMS AND DECISION-MAKING PROCESSES.

WHEREAS, A Pacific/Asian Elderly Conference was held in San Francisco, California on January 15-16, 1981; and

WHEREAS, Many concerns were identified and agreed upon by all the Pacific Islanders; and

WHEREAS, We, the Pacific Island Peoples, are very concerned about the lack of visibility and opportunity by Pacific Islanders to influence national policy at all levels of Government; and

WHEREAS, We are extremely desirous to present our concerns and to work with decision-makers in order to establish our unique needs and problems and to identify the most relevant and appropriate strategies which are responsive to our cultures, values, lifestyles and the social and political conditions under which we all live; and

WHEREAS, As a general practice, we have not had access in the formulation of national policies and programs; and

WHEREAS, There has been a real lack of any vehicle by which Pacific Island concerns are guided into national forums and decision-making processes; and

WHEREAS, We are rarely given the opportunity to become involved in the planning of advocacy efforts by nationally recognized groups; and

WHEREAS, We all share common problems such as manpower resources, community resource programs, and other relevant research and technical resources; and

WHEREAS, Our needs are unique, in terms of the socio-economic development of our islands, our cultures and traditions; and

WHEREAS, Our history is one of oppressed colonized people. Now, therefore, be it

RESOLVED, That the Delegates of the Pacific Islands of AMERICAN SAMOA, COMMONWEALTH OF THE NORTHERN MARIANAS, GUAM, AND TRUST TERRITORY OF THE PACIFIC ISLANDS, in recognizing the common goals of our peoples and the strength that can be gained through unity, hereby pledge our efforts to our mutual benefit under the new designation of "PACIFIC AMERICAN TERRITORIES ON AGING"; and be it further

RESOLVED, That a Mini-Conference on the "PACIFIC AMERICAN TERRITORIES ON AGING", shall be held in Guam on March 18-19, 1981, in order to identify and highlight the specific issues and needs on aging; and be it further

RESOLVED, That the Delegates of the "PACIFIC AMERICAN TERRITORIES ON AGING" shall report its findings to the Executive Director and the Associate Director of the White House Conference on Aging, Washington, D.C., and to the Governors of AMERICAN SAMOA, COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS, AND GUAM, and to the High Commissioner of the TRUST TERRITORY OF THE PACIFIC ISLANDS not later than April 1, 1981; and be it further

RESOLVED, That the "PACIFIC AMERICAN TERRITORIES ON AGING" be given a special concern session at the 1981 National White House Conference on Aging; and be it further

RESOLVED, That the Delegates of the "PACIFIC AMERICAN TERRITORIES ON AGING" shall certify to and attest to the adoption hereof and that thereafter copies shall be transmitted to David Rust, Executive Director; Leon Harper, Associate Director, White House Conference on Aging, Washington, D.C.; Victorina Peralta, Liaison Officer - Minority Group, White House Conference on Aging; Louise Kamikawa, Director, Pacific/Asian Elderly Conference; Gene Handelsman, Acting Commissioner on Aging; Michael Murray, Principal Regional Official, Region IX; John F. McCarthy, Program Director on Aging, Region IX; Honorable Peter T. Coleman, Governor of AMERICAN SAMOA; Honorable Carlos S. Camacho, Governor of COMMONWEALTH OF THE NORTHERN MARIANAS; Honorable Adrian Winkel, High Commissioner of the TRUST TERRITORY OF THE PACIFIC ISLANDS; and Honorable Paul M. Calvo, Governor of Guam.

DULY AND REGULARLY ADOPTED ON THIS 18th DAY OF MARCH 1981.

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1981 WHCoA

Lio Petelo

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the 1981
White House
Conference
on
Aging

Report of the Mini-Conference on Senior Centers

MCR-40

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

MINI-CONFERENCE CONVENOR

SENIOR CENTERS

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National Institute of Senior Centers
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In cooperation with the National Association of Nutrition and Aging Services Programs, The National Association of Meals Programs, The National Association of Area Agencies on Aging, The National Association of State Units on Aging

Arlington, Virginia
January 26-27, 1981

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White House Conference on Aging Staff

Senior Centers

Over the years, senior centers--community based and supported--have demonstrated their ability to enhance the physical, social and emotional well-being of large numbers of older persons. Today the senior center is a community focal point--a gathering place for older persons and a vehicle through which they can access a broad range of services that addresses their needs with dignity and respect, supports their capacity to grow and develop, and facilitates their continued involvement in the community.

A very recent survey conducted by The National Council on the Aging indicates that there are over 8,000 senior centers, considerably more than experts have been projecting. These centers, located in neighborhoods throughout the country, strive to provide information, services and activities that address the needs of the whole person. To achieve this goal, a senior center works cooperatively with other community agencies and organizations and provides an age-specific setting for the delivery of a variety of generic services targeted to older persons.

The senior center, in making services more accessible and acceptable to older persons, helps to maintain and enhance the functioning level of older persons and channels their skills and abilities into productive activities. It should function as part of the community's long term care system, helping to maintain the physical and emotional well-being of older persons, supporting the impaired or frail to forestall or prevent institutionalization and providing respite opportunities for their families. Also, its presence encourages and its services support older persons released from institutional settings.

In a precedent-setting meeting fostered by the 1981 White House Conference on Aging and the U.S. Administration on Aging, the National Council on the Aging's National Institute of Senior Centers convened representatives of "the aging network" for a Mini White House Conference on Senior Centers. The NISC leadership was joined by representatives from the National Association of Nutrition and Aging Services Programs (NANASP), the National Association of Meals Programs (NAMP), the National Association of Area Agencies on Aging (N4A) and the National Association of State Units on Aging (NASUA). The level of cooperation and the degree of commitment to solutions that benefit older persons are all too seldom seen in the human services field. NCOA was pleased to have been able to sponsor and implement this meeting.

Among the major recommendations resulting from the two days of deliberations are the following:

RECOMMENDATION: The national policy stated in the Older Americans Act--recognizing the potential of the multipurpose senior center as a focal point for service delivery and the uniqueness of the senior center as a human service model which is both holistic and preventive--needs to be strengthened and extended.

RECOMMENDATION: The senior center network already in place as a major component in the aging service delivery system needs to be strengthened and expanded to respond to a wide variety of needs.

RECOMMENDATION: Age-relevant formula funding under the Older Americans Act and other funding mechanisms must be maintained and increased to continue the emphasis on community based services offered in congregate settings.

Prior to the mini conference members of the National Institute of Senior Centers' Delegate Council were asked to convene local meetings of service providers and older persons to discuss in the context of senior centers the areas to be addressed by the 1981 White House Conference on Aging. The Delegate Council is an elected body of 64 persons from senior centers, nutrition programs, councils on aging, state offices and area agencies and representing each state plus at-large members to assure representation from minorities and large cities. The resulting issues and recommendations were collated and shared with mini conference participants and introduced into the conference deliberations.

During the two-day mini conference, participants were divided into groups to discuss five topics:

- Senior Centers in an Age Integrated Society
- Senior Centers' Role in Promoting Older Persons as a National Resource and in Creating Opportunities for Supplementing Retirement Income
- Senior Centers' Role in Promoting Physical and Mental Health and Social Well-being
- Senior Centers' Role in Long Term Care
- Senior Centers' Role as Community Focal Points for Service Delivery

The flavor of the discussions and each group's recommendations are presented in the following pages.

Undergirding all of the discussion, however, was concern about funding and the lack of recognition of the benefits of community-based congregate service programs that enable older persons to help themselves and each other and frequently develop as resources for their communities as well.

As practitioners serving the elderly on a daily, face-to-face level, conferees expressed concern about the increasing demand for services, especially by the most vulnerable, in light of the forecast of decreasing service funds. Federal, state and local governments must face this issue. More of the Title XX funds must be earmarked for adult social services and age discrimination legislation must be vigorously enforced as it relates to program funding if senior adult services are to be able to meet the growing needs of communities across the country.

SENIOR CENTERS IN AN AGE INTEGRATED SOCIETY

The senior center, now serving several generations of older persons, provides an atmosphere that supports a sense of identity and community that enables older persons to continue their involvement with and contribution to the larger community. Because conferees believe, based on their experience, that the needs of the elderly are better met when addressed separately from those of other age groups, it is recommended that:

RECOMMENDATION: The senior center, as a major component of the aging delivery system, with a network already in place, should be strengthened and expanded to respond to a wide variety of needs.

RECOMMENDATION: Age relevant formula funding under the Older Americans Act and other funding mechanisms must be maintained and increased to continue the emphasis on community-based services.

RECOMMENDATION: The aging network should have an increased capacity to impact on all Federally funded services that affect older persons.

Conferees agreed strongly that ours is not an age-irrelevant society; consequently, age-specific settings, such as senior centers, are needed as a way to promote and increase options and choices for older persons. Programs for the elderly were initiated because special needs had to be met, and were not being met in other, more generic, programs.

Senior centers are not necessarily segregating, but contribute to an integrated society in that they can facilitate opportunities for volunteers of all ages to interact with older persons and for older persons to serve as volunteers to benefit all age groups, and link older persons to a variety of other age-integrated activities. It is premature to eliminate or dilute this special focus.

Furthermore, the concept of age-integration includes more than young/old; it includes integrating older adults of various ages within the group considered "old." And perhaps more important than age integration is integrating older persons with varied health or economic status or of various racial or ethnic backgrounds. Some older people have a problem interacting with those different from themselves. Agencies have much work to do to better integrate homebound services with congregate programs and facilitate beneficial interaction between the more and less dependent elderly.

Additional Recommendations

- There should be an increase in the capacity of the aging network to provide quality services through training, educational opportunities, resource-sharing, information and developing leadership skills for older adults and professional staff.

- In communities where no senior centers exist, community centers should have separately designated for older persons: space, program, services and staff. Those centers that are publically funded should be required to provide these.

SENIOR CENTERS' ROLE IN PROMOTING OLDER AMERICANS AS A NATIONAL RESOURCE AND IN CREATING OPPORTUNITIES FOR SUPPLEMENTING RETIREMENT INCOME

Senior centers can help to create a more positive image of older persons and assist them to supplement and/or stretch fixed incomes through programs which tap and utilize older persons' skills and abilities. To facilitate this, participants believe that the following recommendations should receive primary consideration at the 1981 White House Conference on Aging and should be implemented as soon as possible:

RECOMMENDATION: State and Federal governments should develop tax credits and incentives for volunteer services in order to encourage older persons to develop as national resources: These may include:

- raising volunteer mileage reimbursement rates to business reimbursement rates and allowing charitable deducations to be taken on the short form

- providing tax incentives for private industry for loaned executives to contribute to programs benefitting older persons

- providing tax credits for older persons who function as volunteers

Discussants focusing on this topic area agreed that senior centers have an educational role in promoting older persons as a resource to the wider community, encouraging and training elder persons to assume responsible roles and helping the community understand and utilize older peoples' capabilities.

One substantive way senior centers can aid older adults to not only contribute to society but supplement their retirement incomes is to locate and expand employment opportunities, especially in the private sector. Centers can also develop job banks and serve as brokers to match up people and jobs. Many centers have developed food co-ops, thrift shops, discount programs, coupon exchanges and clothing or small appliance repair programs to help maximize older persons' dollars.

Additionally, senior centers can help in the preservation of peoples' ethnic heritage by promoting older persons as resources to their younger relatives and their ethnic community.

Barriers that need to be overcome in order to promote older Americans as a national resource and to create opportunities for supplementing retirement incomes include the following: Attitudes--those of the larger community as well as those of some professionals working with older people; disincentives--tax situations that discourage older persons from working; transportation problems, and the misconception that all older people should want to do something.

Additional Recommendations

- Senior centers should be encouraged to develop their role in the community to educate, advocate, convene and broker employment opportunities for older persons.
- Policies should be developed to encourage and help create flexi-time and job sharing positions for older people in all elements of the aging network.

SENIOR CENTERS' ROLE IN PROMOTING PHYSICAL AND MENTAL HEALTH AND SOCIAL WELL-BEING

The varied activities and services integrated within a senior center's program have demonstrated over the years their value in maintaining the physical, social and emotional well-being of older persons. The uniqueness of the senior center stems from its total concern for older persons and its concern for the total person in an atmosphere of wellness. It is, therefore, recommended that:

RECOMMENDATION: Inasmuch as the social well-being of older persons is enriched and enhanced through activities such as recreation, art and education, including nutrition and health education, focal points such as senior centers which provide these activities should be designated and funded.

RECOMMENDATION: More adequate funding should be provided directly to senior centers, or through agencies linked to them, to insure both preventive and restorative health services that maximize the well-being of older persons.

Discussants agreed that older persons have a basic right to physical and mental health and social well-being. Senior centers have traditionally recognized this right by addressing the total well-being of its participants through the provision of an array of services within the center facility as well as outreach type programs. In addition, a senior center serves as a conduit for accessing the physical and mental health and social services available in the community. Senior centers also have an important role to play in providing training opportunities for professionals, paraprofessionals and volunteers who work with older adults in the physical and mental health fields as well as to those who provide social services.

To fulfill their potential senior centers should be offering a broad range of services including counseling, leisure time activities, health screening, health education, information and referral, nutrition and exercise programs. Adult day care may also be considered as a viable service in some centers. The major emphasis placed on preventive services by senior centers must be recognized and made more visible in order to attract funds from sources interested in preventing poor physical and mental health as well as social withdrawal and isolation that threaten older persons.

Barriers to maximizing the senior center's potential to promote the physical and social well-being of older persons include the lack of fiscal support for preventive activities and services; the center's image as primarily a recreation program or a nutrition program and not offering a comprehensive range of services; the inadequate training of center leadership in health-promoting programming; the diversion of funds from health promoting activities and services to case management and home delivered services for the frail.

SENIOR CENTERS' ROLE IN LONG TERM CARE

Preventive in concept, the senior center offers an environment which builds upon strengths, supports independence and responds to changing needs. Representing the least intensive setting in a community's long term care system, a center's services and activities help to maintain an individual's functional capacity and permit an older person to move in and out of more intensive care patterns depending on level of need. To support and encourage such long term care options, it is recommended that:

RECOMMENDATION: Agencies, including senior centers, that provide community-based long term care services should be eligible for appropriate reimbursement from Federal funding sources such as the Social Security Act's medical and social services titles.

Discussants agreed on the value of viewing centers as part of a community's long term care system, not only for the services they can or do provide, but for the peer support and role models potentially available in an age specific setting. Senior centers that serve frail and impaired older persons facilitate interaction between the more and less able, and encourage the development of informal supporting relationships. Also, as a place where trust relationships develop over the years, a senior center can foster acceptance of service when the need arises.

Barriers which prevent a center from fulfilling its potential as part of a community's long term care system were identified as: Predominance of the "health model" as a service delivery pattern, including its emphasis on acute care and "cure" as contrasted with prevention and long term "care" activities; fragmented funding; inadequate community planning and lack of coordination; turf problems; resistance to serving special groups and problems in integrating physically and mentally impaired.

Additional Recommendations

- Housing for the elderly projects should be required to include support services offered through senior centers.

- A single long term care plan should be developed within each Planning and Service Area and the governor should designate the Area Agency on Aging as the lead agency in plan development.

- Senior centers should be assisted to provide incentives that will strengthen and maintain older persons' informal supports.

SENIOR CENTERS' ROLE AS COMMUNITY FOCAL POINTS FOR SERVICE DELIVERY

Recognizing the continuing need for separate legislation to positively impact on the lives of older Americans, conferees believe that the Older Americans Act and its current implementing structure should be maintained, strengthened and expanded. Since senior centers have been a component of the aging network since the inception of the Older Americans Act,it is recommended that:

RECOMMENDATION: Federal policies and legislation should continue to recognize the strengths of the multipurpose senior center and further reflect its uniqueness as a human service model which is both holistic and preventive by further identifying and supporting its potential as a community focal point for service delivery.

RECOMMENDATION: Legislation, regulations and funding mechanisms be examined and modified where necessary to help eliminate duplication and inconsistencies in programs by fostering the maximum coordination of services between senior centers and other components of the service delivery system.

Conferees voiced their belief that any service delivery system should be built on local needs and priorities, preserving the rights of community option. Because senior centers have developed across the country under a variety of auspices, their focus and functions differ. It was generally felt, however, that all function as or have the potential to function as a community focal point.

Most participants indicated that the regulations were somewhat unclear regarding focal point implementation. General consensus, however, seemed to be that, whether designated a focal point or not, senior centers have a vital role to play within their service delivery system, a role often misunderstood by the rest of the aging network.

Senior centers can be a front door, an entry point into the system and function as a catalyst for services. As a place where older people feel comfortable and trusting, the center can excell at brokering services on an individual basis. Center leadership needs to think in terms of services in and through the center; thus, linkages to provide access to other programs and services become very important. The coordination of these services requires high priority and skilled staff.

Among the barriers to increasing the center's role in effective service delivery were: The uneven development of agencies within the network making cooperation and coordination difficult; the protection of turf by various agencies and the fears of collocation and staff sharing; lack of communication among service providers, and the lack of adequately trained staff. Coordination of services is not a simple task, but the feeling was expressed that the expertise many senior center administrators have in bringing services together often goes unrecognized. At the same time, it is important to remember that there are many different ways in which senior centers can function to access services and that these many ways can all be correct.

Additional Recommendations

- Federal policy should reflect and support the senior center as an important cost effective service delivery mechanism for
  - brokering services
  - fostering a team approach of communitywide agencies
  - addressing inflationary and energy crises affecting older people.

- The Administration on Aging should help increase the ability [illegible] the aging network to attract, develop, maintain and sensitize highly skilled personnel by continuing to offer training and educational opportunities for professionals in the field, and for older people who would like to assume a leadership role in their own delivery system.

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The following Federal agencies/ Congressional committees sent official observers:

U.S. Administration on Aging
U.S. Senate Special Committee on Aging
U.S. House Select Committee on Aging

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Report of
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Black Aged

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INTRODUCTION

NCBA is pleased to submit the summary of the following recommendations developed by more than 1,500 delegates who attended the three Mini-White House Conferences on Aging in Detroit, Atlanta, and Los Angeles. The recommendations, along with the justification from these proposals, reflect the collective thinking of conference participants from all walks of life. The proposals were developed in a democratic fashion at workshops at the mini-conferences.

NCBA wishes to pay special tribute to the White House Conference on Aging and its staff for the opportunity to conduct these preliminary conferences. The proposals provide a blueprint for important actions that can produce at long last a national aging policy for older Black Americans.

NCBA was not able to include every recommendation developed at the three mini-conferences because of space limitations. However, we have selected the major findings and recommendations for this chapter. We urge the delegates at the national White House Conference on Aging to give careful and serious consideration to these measures.

NCBA is also eager to provide further information or to respond to any questions concerning these policy proposals and findings. We look forward to working with the White House Conference on Aging staff and delegates to make the 1981 White House Conference on Aging the best ever.

INCOME -- Major Findings

The incidence of poverty increased by almost 400,000 between 1978 and 1979 for persons 65 years or older -- from 3.2 million to 3.6 million. This represented the largest increase for the elderly since pov-erty statistics were first tabulated about 20 years ago. Poverty is a bare bones existence under the government's definition. In 1979, single aged persons were considered poor if their income was below $3,472 or less than $67 per week to pay for housing, food, medical care, transportation, utilities, and other everyday necessities. A two-person household with an aged head was classified as poor if they had income below $4,364, or less than $84 per week.

"PROTECTING THE RIGHTS OF THE ELDERLY."

The depressing economic conditions for senior citizens in general can ordinarily be multiplied two or three times for older Black Americans because they suffer from multiple jeopardy since they are old, Black, and quite often poor. Older Blacks are almost three times as likely to be poor as elderly Whites. Black elderly poverty as a share of the total incidence of poverty has increased over the last decade. Nearly 36 percent of all aged Blacks live in poverty, in contrast to 13 percent for elderly Whites. In 1979, 55,000 older Blacks were added to the poverty rolls, raising the total from 662,000 to 717,000. This represents the highest number of impoverished older Black Americans since 1966, when 722,000 were poor. In addition, almost 300,000 aged Blacks had incomes within 25 percent of the minimal poverty line. This means that one million Blacks 55 years or older are either poor or marginally poor. The net inpact is that one out of every two Blacks (49 percent) either live in poverty or so close to it that he or she really cannot appreciate the difference.

Blacks who live alone or with nonrelatives are particularly disadvantaged. Quite often, they suffer from greater extremes of deprivation. Poverty is especially widespread among elderly unrelated Black women. About five out of eight live in poverty. More than four out of five are either poor or marginally poor.

A strong and healthy Social Security system and an effective Supplemental Security Income program are vital for older Black Americans because these two sources constitute the bulk of their income. Most older Americans have income from assets -- such as interest from savings accounts and dividends from stocks -- but not older Blacks. Elderly Whites are three to four times more likely to have income from assets than aged blacks. Approximately 63 percent of White males 65 or older and 40 percent of elderly White women receive asset income -- in contrast to 16 percent for Black aged males and 12 percent for Black older women.

Social Security benefits are, on the average, lower for Blacks than for Whites -- ranging from 74 to 88 percent of the amounts payable to Whites. Social Security has helped to compensate for some disadvantages that Blacks have encountered during their working years. However, the greatest problems affecting Blacks -- lower earnings and higher unemployment during their working years -- are still beyond the control of a wage-related program.

SSI guarantees a minimum monthly income of at least $238 for qualifying individuals and $357 for elderly couples. Blacks account for about one-fourth of all aged SSI recipients and three out of ten blind and disabled SSI beneficiaries. SSI poses some serious problems for older Black Americans. First, the minimum monthly income standard is below the government's own official poverty index.

Second, there are anti-family provisions which discourage children from helping their parents or grandparents. An SSI recipient's benefit, for example, is reduced by one-third if he or she receives maintenance and support while living in the household of another.

Recommendations

o Recommendation: The special minimum monthly Social Security benefit should be at least 10 percent above the poverty line for long-term workers who have been employed at low wages throughout their lives.

o Rationale: The special minimum monthly benefit is designed to help lower paid workers with long periods of covered employment under Social Security. It is, in effect, computed by multiplying $14.45 (July 1980) by the worker's number of years of covered employment above ten but not greater than 30. Thus, a worker at age 65 with 30 or more years of coverage is entitled to a special minimum monthly benefit of $289 -- $14.45 x (30 - 10 = 20) = $289. However, this special benefit is still not adequate for many older Americans, especially elderly Blacks and others who have worked all of their lives for low wages.

o Recommendation: Congress should not enact legislation to increase the eligiblity age for full Social Security benefits from 65 to 68.

o Rationale: Older Blacks -- as well as other aged minority members -- are likely to be hurt the most by a proposal to raise the eligibility age for full benefits. In 1977, average life expectancy at birth was 64.5 for all non-White males -- the vast majority of whom were Black -- or 5.4 years less than for White males.

o Recommendation: The entire Social Security tax rate should be used to finance retirement, survivior, and disability benefits, and the Medicare Hospital Insurance program should be financed by earmarked corporate and individual income tax.

o Rationale: In 1981, the Social Security payroll tax rate for employers and employees, each, is 6.65 percent on up to $29,700 of covereage earnings. However, the Old-Age and Survivors Insurance Trust Fund -- the largest of the Social Security trust funds -- will face cash flow problems in mid-1982 because of the sick state of our economy. High unemployment has siphoned off funds from the OASI trust fund, while double-digit inflation has driven up program costs. If Medicare Hospital Insurance could be financed entirely by general revenues, the existing HI rate could be transferred to Social Security cash benefits to maintain the financial integrity of Social Security. This would also make the overall financing for Medicare more progressive and would maintain the present overall payroll tax rate at about its present level well into the future.

o Recommendation: The Social Security earnings limitation should be liberalized for beneficiaries under age 72. In addition, the same earnings limitation should be applicable for beneficiaries under age 65 as is available for those 65 to 71 years old.

o Rationale: Social Security beneficiaries 65 to 71 years old may earn $5,500 in 1981 before their benefits are reduced by $1 for each $2 of earnings above this amount. Persons 72 or older (70 in 1982) are not subject to the earnings test. Individuals receiving Social Security under 65 years of age may earn $4,080 before they are subject to the $1-for-$2 reduction. The existing earnings limitation should be liberalized to encourage more people to work after age 65. A higher earnings ceiling would also help older Blacks who need to work to supplement their Social Security and any other retirement income that they may have.

o Recommendation: Social Security beneficiaries should receive twice-a-year cost-of-living adjustments (COLAs) when the annual inflation rate is high (8 percent or greater). The COLA mechanism should be based upon an elderly Consumer Price Index which reflects rising prices. Congress should not enact any legislation cutting back inflation protection by placing a cap or ceiling on COLAs; basing adjustments on rising prices or wages, whichever is lower; or any change which otherwise reduces existing protection.

o Rationale: Twice-a-year COLAs during periods of rapid inflation would keep Social Security benefits more current with rising prices. A special elderly CPI would measure more accurately the impact of inflation upon older Americans. NCBA opposes cutbacks in COLA protection because our Nation can take more effective and equitable actions to halt rising prices than to thrust the elderly into the front ranks as inflation fighters. A cap on COLAs will only add to the economic misery of older Americans. It will force more elderly persons on to the poverty rolls. And, it will be especially onerous for aged Black Americans, particularly the one-third who now live in poverty.

o Recommendation: The federal Supplemental Security Income program should guarantee the aged, blind, and disabled a minimum income at least 10 percent above the poverty line.

o Rationale: Nearly 3.6 million persons 65 were poor in 1979, or about one out of every seven older Americans. America has the resources to allow all older persons to live in dignity and self respect. What is needed is the commitment. NCBA believes the most cost effective way to implement this objective is to elevate the SSI income standards to a level to eliminate poverty for older Americans.

o Recommendation: The SSI benefit standard should not be reduced when aged, blind, or disabled recipients live in the household of another.

o Rationale: Major barriers exist now for children to assist their parents or grandparents, such as the one-third reduction in the benefit standard for SSI recipients who live in the household of another. This provision penalizes elderly people who are helped by their children or grandchildren. In the long run, it may cost the government more because some of these older persons may wind up in institutions at a much higher public cost than if they could have been maintained in a relative's home.

CRIME -- Major Findings

Freedom from fear is clearly one of the top priorities for older Americans, especially low-income aged Blacks living in urban areas. Delegates at the 1971 White House Conference on Aging made this point emphatically. It was reaffirmed in a 1974 Louis Harris Poll (conducted for the National Council on the Aging) which revealed that crime headed the list of serious concerns among the elderly.

Many elderly Blacks today live under a form of "house arrest" -- cut off from their friends, family, and vital services. Large numbers are afraid to answer a knock at their doors. The harsh reality is that a substantial number -- perhaps millions of older persons -- live isolated in their own residences, apprehensive about venturing out of their neighborhoods.

A substantial amount of crime against older Blacks goes unreported because of the fear of reprisals. Some victims remain silent because of a widespread feeling of futility, since few criminals are apparently ever prosecuted, convicted, and imprisoned.

Recommendations

o Recommendation: Crime should be a separate agenda item for the 1981 White House Conference on Aging.

o Rationale: The fear of victimization ranks very high on the list of elderly concerns. It deserves special attention at the White House Conference on Aging.

o Recommendation: Congress should enact victim compensation legislation -- administered by appropriate state agencies -- which would include the following minimum provisions:

- Emergency compensation should be made in hardship cases.
- Law enforcement officials should notify victims of their right to compensation and where they can obtain assistance in completing forms.

-- No minimum loss requirement or means test should be imposed for victims to qualify for compensation.

-- An efficient and administrative system should be put in place to eliminate red tape during investigations and to expedite payments.

-- The Administering agency should maintain round-the-clock service for crime victims.

o Rationale: Crime imposes hardships upon older Americans, and especialy aged Blacks. But, the economic impact is perhaps most devastating since millions of elderly persons are struggling on very limited incomes, particularly older Blacks. The move to compensate victims represents a compassionate response and an important step to recognizing the harsh impact of crime upon persons suffering personal injury or property loss.

o Recommendation: The Civil Rights Commission should appoint a task force to investigate "hate" groups (e.g., the Ku Klux Klan, the American Nazi party, and others) which perpetrate violence against Blacks, and especially older Blacks. A majority of the task forces members should be Black. The task force should be appointed in consultation with NCBA and other major national Black organizations. A strike force should be established within the Justice department, under the direction of a special prosecutor, to prosecute those violating the civil rights of Blacks.

o Rationale: The stepped-up racially motivated violence directed at Blacks and other minorities demands high level attention to protect the civil rights and other rights of victims. Vigorous law enforcement by the Department of Justice of existing civil rights legislation is essential to insure justice and to deter would-be violators.

o Recommendation: The Adminstration on Aging should take the lead role in working with the media, other government agencies, private organizations and the elderly to educate older Americans about effective crime prevention techniques and available assistance for older crime victims.

o Rationale: Demonstration projects sponsored by the Law Enforcement Assistance Adminsitration, the Community Services Administration, and AoA provide abundant evidence that much crime can be prevented through community efforts and at a comparatively low cost. Many crime prevention techniques are already available, including neighborhood watches, security checks, the installation of security devices, escort services, and others. They have been tested, and the results have generally been positive. And, they can easily be replicated in most communities throughout our Nation.

o Recommendation: Victim restitution measures imposed by the criminal justice system should require the offender to fully indemnify the victim by making payment and/or providing services, whichever is appropriate. Victims should be informed of the status of their case and the objective of the restitution. Victims should be able to comment on the details of the restitution plan, including the payment schedule and amount. In addition, they should be able to receive copies of the criminal proceedings without charge.

o Rationale: Victim restitution can provide the courts with greater options if there is effective planning and coordination. Victim restitution can be advantageous in other ways because it can (1) increase the efficiency of the criminal justice system, (2) help victims at a time of need, and (3) increase the likelihood of rehabilitating the offender.

EMPLOYMENT -- Major Findings

Our Nation lacks a clear-cut and effective policy to maximize job opportunties for older workers. Any national employment policy for older Americans must recognize the individual's right to work or not to work.

Ideally speaking, our Nation should provide older persons with a wide range of options, depending upon their needs and desires. At a bare minimum, these alternatives should be available for older persons:

-- To retire in dignity or to work;
-- To work full time or part time; and
-- To work for pay or as a volunteer.

Many older Black workers are discovering that they are among the first to be fired and the last to be hired. Functional capacity -- not chronological age -- should determine whether a person is hired, fired, promoted, or demoted.

False stereotypes still exist about the desirability and feasibility of hiring older workers. Several studies, however, show that older workers perform as well on the job as their younger counterparts, and in some cases noticeably better. Major educational efforts are needed to persuade many employers that it makes good sense -- economically, socially, and otherwise -- to hire older Americans.

Recommendations

o Recommendation: Management and labor -- through collective bargaining -- should attempt to increase opportunities for flexible work arrangements, such as part-time work with proportional fringe benefits, shared jobs, educational benefits to train for second careers and other accommodations which extend the worklife for older workers.

o Rationale: Work today is too often an "all or nothing" proposition for older Americans. Many elderly persons -- as well as younger Americans -- would prefer greater flexibility because of family responsibilities, personal preferences, or other factors. Innovative job arrangements -- including flexi-time, part-time employment, trial retirement, compressed work schedules, and others -- can increase worker productivity and morale, as well as accommodate a worker's preferences and family responsibilities.

o Recommendation: The Title V Senior Community Service Employment programs should be expanded to provide more job opportunities for low-income persons 55 years or older.

o Rationale: Title V has been an effective program, free of fraud and abuse. It has enabled low-income older persons to help themselves, while helping others in their communities at the same time. The Senior Community Service Employment program has proved to be an effective and dignified weapon to combat poverty among the elderly, and it deserves to continue to grow.

o Recommendation: The Comprehensive Employment and Training Act (CETA) and other federally funded training, vocational education, and other manpower programs should be held specifically accountable by the Congress by the year 1983 for equitable assistance to all age groups or face cutbacks or other sanctions.

o Rationale: By any barometer one would choose to use, middle-aged and older workers have been underrepresented or largely ignored by CETA work and training programs. The situation is not likely to improve without additional Congressionally-mandated directives for prime sponsors to be more responsive to the needs of middle-aged and older workers.

o Recommendation: The federal government and the private sector should promptly undertake a major research and dissemination effort to accomplish the following objectives by 1985:

-- Develop and test age-neutral occupational performance appraisal tools and personal functional capacity measures.

-- Gather and disseminate information to employers and the general public concerning the skills, experience, and productivity of middle-aged and older workers.

o Rationale: The 1978 Age Discrimination in Employment Act Amendments, in effect, raised the mandatory retirement age to 70 for millions of workers in the private sector and abolished mandatory retirement completely for practically all federal employees. These developments provide powerful reasons to determine more precisely occupational performance measures. Additional pressure will build if a serious attempt is made to eliminate mandatory retirement entirely in the private sector.

EDUCATION -- Major Findings

Lower educational attainment contributes markedly to the generally higher unemployment levels among elderly Blacks, as well as their lower economic status. The median level of education for Blacks (both sexes) 60 to 64 years old is barely above the eighth grade. The median level for the elderly Blacks (those 75 or older) is only slightly above "functionally illiterate." (Persons are considered "functionally illiterate" if they have completed less than five years of schooling.)

Many older Blacks have discovered that their skills have been outdistanced by technological change. Large numbers encounter problems in obtaining necessary education to learn new skills or to sharpen existing marketable skills to compete in the job market.

Recommendations

o Recommendation: Colleges and universities should be provided technical assistance to help them respond to the learning needs of older adults through the redesign of instructional offerings, the retraining of faculty, and the enhancement of their non-instructional services.

o Rationale: College programs have historically focused on youth, providing traditional academic offerings only. Special help is needed to adapt facilities, administrative procedures, and instructional resources to the needs of older learners. It is in the national interest to maximize the substantial public investment that has been made in postsecondary education by providing this necessary technical assistance.

o Recommendation: National incentives should be provided to insure that the Black aged are fully informed and properly counseled about available educational opportunities.

o Rationale: Existing funding for guidance and counseling services for adults is too limited to have a significant impact upon the Black and other minority aged. Special efforts must be made not only to inform these individuals about available learning opportunities, but also to help them overcome psychological, logistical, and other roadblocks to further learning in order that they can be motivated to take advantage of these opportunities.

o Recommendation: A careful and thorough study should be conducted of the educational needs of the Black aged to properly assess the potential number of adult learners in this group, the precise nature of the necessary instructional services, and the most effective strategies for meeting these needs.

o Rationale: Too little is known about the learning needs of the Black aged, and how these needs might be most effectively addressed. A thorough study can provide valuable information for possible future policies.

o Recommendation: Funding for the Foster Grandparent program should be expanded to permit older Blacks and other minorities to receive the special training and orientation to permit them to provide quality child care services in their communities in order that young mothers who want or need to work can do so.

o Rationale: Several highly successful demonstration programs have shown that senior citizens can be a valuable resource in their communities if given a suitable opportunity. The need for child care assistance is likely to intensify as more women of childbearing age enter the labor market without sufficient wages to pay fully for necessary child care.

o Recommendation: National incentives should be provided to train older, literate Black Americans so that they might tutor their less literate peers in the fundamentals of reading, writing, and arithmetic.

o Rationale: "Each one teach one" is a concept that has been effectively used in the British campaign against adult illiteracy. At present, adult education programs reach only a tiny fraction of those who qualify for basic literacy education, high school completion, and English as a second language. At the same time, there is a growing number of literate older Americans who, with proper advance training, can be forged into an effective army to combat illiteracy among their friends and neighbors.

o Recommendation: Every effort should be made to insure that the Black aged have access to continuing education opportunities (under the 1980 Higher Education Act) which strengthen their economic well-being, allow them to make effective use of their leisure time, and prepare them for volunteer service.

o Rationale: Education is as important for older Americans as it is for younger Americans. A recent NRTA-AARP study demonstrates the importance of vocation-related learning. Approximately 30 percent of those approaching retirement age feel that they cannot afford to retire, and 12 percent of retirees would like to re-enter the labor force.

RESEARCH -- Major Findings

Research is a fundamental tool for a society to obtain the necessary knowledge to improve the quality of life for older Americans and to adapt to fast changing developments. The private sector has long recognized the value and importance of research in order to remain competitive.

Aging research, however, has been relegated to a lower level on the federal priority ladder. Funding continues to be inadequate to meet the demonstrable need. Title IV research under the Older Americans Act has suffered major cutbacks in funds at a time when double-digit inflation is driving up costs.

A clear need exists to bolster aging research and to develop a more effective procedure to publicize the results of research so policymakers can make more informed judgments about its value and worth.

Recommendations

o Recommendation: Cost-benefit analyses should be undertaken to determine the most effective way to improve the economic well-being of older Blacks, such as changes in Supplemental Security Income or Social Security.

o Rationale: Poverty is substantially higher among older Blacks than among aged Whites. Elderly Blacks are almost three times as likely to be poor as aged Whites. The economic prospects for older Blacks are not encouraging at this time unless federal income maintenance programs are strengthened. However, this must be achieved in the most cost-effective manner because of the existing mood of austerity.

o Recommendation: Research should be undertaken to determine to what extent urban areas are increasingly becoming centers for the Black aged and other elderly poor. In addition, research should be funded to evaluate the impact of these demographic trends on social service delivery in the central cities.

o Rationale: Existing research makes it abundantly clear that substantial concentrations of older Black Americans live in central cities. However, existing information about the urban elderly Blacks is oftentimes fragmented, incomplete, or sometimes inaccurate. Additional research is necessary to build a more adequate knowledge base to provide the framework for developing sound and sensible policies to come to grips with their everyday problems.

o Recommendation: Additional studies should begin on the impact of (1) revising Medicare to make it available to all Americans regardless of age or (2) establishing a comprehensive national health insurance program.

o Rationale: Rapidly rising health care costs for all Americans provide compelling reasons to either expand protection under Medicare or provide additional protection through another mechanism, such as national health insurance. A clear need exists to develop an effective health care system that impacts upon the total life cycle of Black Americans because much of our shorter life expectancy is attributed to (1) a higher infant mortality rate, (2) a greater maternal mortality rate, and (3) excessive hypertension among middle-aged Blacks.

o Recommendation: Research should be conducted to determine the relationship between the Black elderly's belief in folk medicine and their consumption of home health and other services.

o Rationale: Preliminary research indicates the importance of folk medicine in the self-health care of the Black aged, who for so long have been denied access to our more "conventional" health care system because of economic and other reasons. Further research can perhaps develop recommendations to make existing service delivery systems more effective and helpful in assisting those who still cling to folk medicine remedies.

HOUSING -- Major Findings

Housing is the number one expenditure for most older Americans. They frequently spend about one-third of their income for housing, and a significant percentage spend substantially more -- especially low-income older Blacks who are unable to live in federally assisted housing.

Many older persons are discovering that they are in practically an impossible housing situation. Rapidly rising energy costs, property taxes and maintenance expenses make it extremely difficult for elderly individuals to continue to live in their own homes. Yet, they cannot find suitable and affordable alternative housing, such as an apartment.

Large numbers of older Americans -- and especially elderly Black Americans -- live in inadequate housing. About one out of five elderly households is projected to live in physically inadequate housing. However, the proportion is twice as great for elderly Black families. About two in five is inadequately housed. These figures would be substantially higher under more stringent standards of "adequacy." In rural areas, Black households containing an elderly person (over 60) were found to be lacking some or all plumbing facilities in 55.6% of owner-occupied residences and 85.8% of rental units.

Recommendations

o Recommendation: The regulations for rent adjustments for the elderly should be amended to disregard Social Security and SSI cost-of-living increases as a basis for raising rents.

o Rationale: Existing regulations require the elderly's rent to rise when their Social Security or SSI benefits increase. This merely undercuts the purchasing power of needy older per-sons.

o Recommendation: A federal commitment should be established to produce 4 million assisted elderly housing units during the next ten years.

o Rationale: The 65-plus population is increasing now about 600,000 per year. Many older persons live in inadequate housing. Others are "overhoused" after their children leave. The need for new, rehabilitated, or restructured housing for older persons will intensify in the years ahead.

o Recommendation: Increased federal funding should be made available to assist elderly persons to remain in their homes. These efforts should be combined with an adequately funded and properly monitored maintenance and chore services program.

o Rationale: Many elderly persons have lived in their homes for 20 or 30 years or longer. They are near their family, friends, and church, and they prefer to live in their existing neighborhoods. However, rapidly rising energy costs, property taxes and home repairs are forcing older persons to leave their homes or to allow their homes to deteriorate as inflation shrinks their purchasing power.

o Recommendation: The AoA network should take more of a leadership role in disseminating information about housing programs and related services for older Americans.

o Rationale: Numerous regulations, laws, and policies provide housing benefits and sevices for the elderly. However, many older Americans have only a superficial knowledge or they are totally uninformed about available programs that can assist them. A coordinated outreach, education, and information and referral program can identify elderly persons who qualify for housing assistance and make certain that they receive it.

LONG-TERM CARE -- Major Findings

Older Blacks have historically been underserved by long-term care institutions. Our people constitute only a tiny fraction of all persons in skilled nursing homes. The 1977 National Nursing Home Survey revealed that only about one out of 25 residents in skilled nursing homes -- or 4 percent of the total -- was Black. In sharp contrast, White non-Hispanics represented more than 93 percent of the total, or 23 out of 25 skilled nursing facility residents. Yet, aged Blacks constitute more than 8 percent of all persons 65 or older. Older Blacks accounted for 7 percent of all residents in Medicaid intermediate care facilities, which serve low-income chronically impaired persons. However, elderly Blacks accounted for 22 percent of the total aged poverty population in 1977.

Several factors account for our lower participation rate in long-term care facilities:

-- Many Blacks simply cannot afford the high cost of skilled nursing care. In 1977, the average monthly charge for residents in skilled nursing facilities was $880. For all nursing home residents, the average cost amounted to $689 a month. These figures would be substantially higher today.

- -- Our people are still victims of discrimination -- whether covert or overt -- even though this practice is prohibited.
- -- Some facilities, which serve Blacks primarily, are unable to meet fire, safety, and other code requirements because of limited resources.
- -- Nursing homes are oftentimes viewed with suspicion and deep concern by older Blacks because of news accounts about dreadful conditions that exist in some facilities.

Recommendations

o Recommendation: The Medicaid Community Care Act (H.R. 6194 - 96th Congress) should be enacted into law as soon as possible.

o Rationale: Large numbers of older Americans are unnecessarily or prematurely institutionalized at a much higher public cost, when they could receive more appropriate care in their communities or homes. The Medicaid Community Care Act would help our Nation to develop a more balanced approach to meeting the health needs of older Americans. This would be achieved by promoting in-home and community care under Medicaid for the "at risk" aged and disabled population. The bill would increase federal matching funds for in-home and community-based services for the "at risk" population by 25 percent, up to a maximum of 90 percent, if states meet certain requirements, including:

- -- Provide a comprehensive assessment of individuals who probably would need long-term care skilled nursing or intermediate care facility services if in-home and community-based services would not be available;
- -- Provide a wide range of home and community-based services for "at risk" persons who can continue to remain in their communities; and
- -- Establish reimbursement limits at a rate not exceeding the level of nursing home care.

o Recommendation: The nursing home ombudsman program should be adequately funded and maintained to assure that the rights of nursing home patients are fully protected.

o Rationale: The 1978 Older American Act directed state offices on aging to establish an ombudsman to (1) investigate and resolve complaints made by or on behalf of nursing home residents; (2) monitor the development and implementation of policies affecting long-term care facilities; (3) provide information; (4) train volunteers and promote the development of citizen organizations to participate in the program. The ombudsman program has the potential to improve conditions for nursing home residents. It must, though, be adequately funded and supported to implement this goal.

o Recommendation: Long-term care should be reflective of the whole person and should not simply focus upon health care. Long-term care should utilize supportive services in existing programs to provide a more comprehensive and coordinated response to the elderly person's needs.

o Rationale: Long-term care should include a broad continuum of care providing health related as well as supportive social services. This is essential because the elderly's health care needs may have social, psychological, or other roots.

o Recommendation: Information pertinent to health resources in the community must be coordinated, easily available, comprehensive, and accurate. In addition, the information must be provided by persons who are well trained and knowledgeable about the special needs of the elderly, with particular emphasis on preserving the dignity and worth of the Black elderly.

o Rationale: Many elderly Blacks are unaware of available community health services and other health resources, for a variety of reasons. Appropriate information and referral services -- combined with an aggressive outreach and education campaign -- can help assure that they receive needed services.

o Recommendation: Medicare should be broadened to cover adult day care, hospice care, and ambulatory care.

o Rationale: Medicare does not cover many major health needs of the Black elderly. Consequently, important health problems may simply go unattended. Coverage of hospice care, day care, and other forms of care would provide a more balanced and responsive approach to the elderly's health needs.

MENTAL HEALTH -- Major Findings

Mental health services for elderly Black Americans are limited and not effectively delivered. Federal legislation has been strengthened by enactment of the Mental Health Systems Act. But, existing laws require further modification and improvement.

Focused attention is needed to strengthen existing laws where appropriate and to pass new legislation at the federal and state levels to assist elderly Blacks who may require humanistic mental health services. Further, a need exists for more focused interagency agreements so that federal agencies coordinating services will be in closer harmony.

Recommendations

o Recommendation: The Director of the National Institute of Mental Health should act expeditiously to name an Associate Director for Minority Concerns. This office should be adequately staffed and funded to assure that it fulfills congressional intent.

o Rationale: At present, there is a dearth of minority individuals with expertise in geriatric mental health who serve in critical evaluative, advisory, and decision-making positions affecting federal policies for the aged. It is essential that this situation be redressed if the mental health care needs of the minority elderly are to be appropriately considered at the national level.

The Mental Health Systems Act -- particularly the provision to establish the position of Associate Director for Minority Concerns at the National Institute of Mental Health -- represents a positive step to focus on the special problems of minorities. This office must be appropriately implemented and supported to be effective.

o Recommendation: Professional health schools (e.g., schools of medicine and pharmacology) should require geriatric/gerontology course work.

o Rationale: Some experts estimate that perhaps 20 to 25 percent of all persons 65 or older have mental health problems. Yet, they account for only about 2 percent of all patients of private practitioners and 4 percent of patients treated at Community Mental Health Centers.

Few psychiatrists and other health related personnel have a thorough understanding of the special problems confronting geriatric patients. Quite often they take a dim view of the treatability of the aged's mental disorders. A prophesy of "irreversible brain damage" can be self-fulfilling if half-hearted attempts are made to correct the disorder. According to the National Institute on Aging, 10 to 15 percent of organic brain syndrome cases, or "senility," is reversible and 30 percent is treatable. Yet one out of every two nursing home residents is diagnosed as "senile."

o Recommendation: Training and education programs should be strengthened to incorporate content on the Black elderly. These programs should include content in the core curriculum of psychology, social work, psychiatry, and psychiatric nursing. Attention should be given to an intergenerational focus for paraprofessionals.

o Rationale: This would help to make mental health professionals and paraprofessionals more aware of the special problems and needs of aged Blacks. The greater vulnerability of aged Blacks and other minority aged members is statistically evident -- in terms of greater susceptibility to mental and physical illness and a shorter life expectancy when compared to Whites.

o Recommendation: Outreach services should be expanded to identify Black elderly persons in need of humanistic mental health services. Outreach services should be utilized to move persons to sources of assistance for mental health and supportive services.

o Rationale: Older Blacks represeant a potentially vulnerable population. They frequently bear the medical and mental ills of a lifetime of inadequate income, nutrition, health care, and social opportunity. Advancing age imposes further setbacks and stresses to the indignities and illnesses of the past. NCBA strongly believes that mental health services should be accessible to those in need.

Large numbers of older Blacks are unaware of available mental health services. Outreach efforts are necessary to help assure that they receive the services which they now need.

o Recommendation: Factual knowledge about the Black elderly is lacking. Funding for research on the mental health needs of elderly Blacks should be increased.

o Rationale: A close look at our statistical reporting system reveals that important information gaps exist concerning the mental health needs of older Blacks. Well conceived research would help to close these gaps and provide a basis for improving public policy.

o Recommendation: Affirmative action policies should be expanded to help assure that more Black mental health professionals and paraprofessionals are trained.

o Rationale: The number of minority professionals in the fields of mental health and gerontology is growing, but is still relatively small. In 1977, there were only about 400 Black psychiatrists in the entire country. The supply of other Black mental health workers is small, and the total with special geriatric training is even smaller.

RURAL ELDERLY -- Major Findings

Older Blacks living in rural areas are typically the "people left behind." Many of these rural hamlets are without doctors, dentists, druggists, nurses, lawyers, and other service providers.

Public transportation is frequently nonexistent. The net impact is that large numbers live in "solitary confinement," cut off from their friends, family, and service providers.

Quite often, greater extremes of deprivation are starkly apparent in the rural slums than in the central cities. Ramshackle, deteriorating, and structurally unfit housing is readily evident.

Sanitary conditions are often primitive and totally inadequate for the 20th century. This takes its toll in numerous ways: higher infant mortality rates, a higher incidence of illness, a shorter life expectancy, and generally a lower standard of living.

Recommendations

o Recommendation: Congress should increase funding for rural housing programs (such as section 502, 504, and 515) of the Farmers Home Administration. FmHA should give priority to authorizing loans to public and nonprofit private agencies, such as churches, to build congregate housing for the rural elderly with the greatest economic need.

o Rationale: It is estimated at that 60 percent of the substandard housing in the United States is found in rural areas. Approximately one out of four of these units is occupied by an elderly person. More than 2 million rural homes do not have running water, are uninsulated, and are costly to heat.

o Recommendation: Funding for the home delivered meals program under the Older Americans Act should be increased by 100 percent, and 50 percent of this additonal funding should be spent in rural areas.

o Rationale: Present funding for home delivered meals is not sufficient to meet the needs of socially and economically deprived rural older Americans. Funding for home-delivered meals can enable older persons to remain in their homes, rather than being placed in a nursing home at a substantially greater public cost.

o Recommendation: The Department of Labor and the Administration on Aging should work together to promote greater employment opportunities for older persons in rural areas.

o Rationale: The rural elderly have fewer opportunities than those living in urban areas to earn supplemental income. Many rural older Americans are ready, willing, and able to work. However, they lack fundamental education to compete in our complex and mechanized society today. Some rural older Americans need to work because inflation is shrinking their purchasing power. Others want to work because of the psychological value.

o Recommendation: Medicare should be expanded to cover a broader range of services, including essential out-of-hospital prescription drugs, homemaker services, eyeglasses, dental care, and others. Doctors and other service providers should be required to accept assignments to participate in the program.

o Rationale: Medicare represented a landmark victory for older Americans. However, important gaps in coverage still exist. In 1977, average per capita out-of-pocket expenses for the elderly amounted to $462. Many older Black Americans and other elderly persons are now being saddled with additional medical payments because physicians and other health providers do not accept assignments. Medicare pays only 80 percent of reasonable charges for covered services after the patient pays a $60 deductible charge either from his or her own resources or other public or private plans.

COMMUNITY SUPPORT SYSTEMS -- Major Findings

An adequate income in retirement is the foremost need of older Black Americans. However, an effective income strategy must mesh with sound social services policies.

Any social services strategy must recognize the unique characteristics of rural and urban Black persons. This must be reflected in policy formulation to accomplish the effective delivery of relevant community services. These special factors include consideration of the older Black American's historical experience, family structures, and the traditional supports provided by churches and social clubs. The informal supports can be utilized to a particular advantage in assuring respect and dignity, but they are limited in meeting today's overwhelming needs.

A clear need also exists today to coordinate the full range of services and entitlements to eliminate (1) certain incomprehensible programs that consumers cannot utilize and (2) duplication of services that drive up program costs.

In addition, nutrition, transportation, in-home support, health and mental health, economic support and recreational services must be designed to meet the special psycho-social and economic needs of clients in rural and urban areas. Services should be targeted to the poor and near poor elderly.

Recommendations

o Recommendation: The Administration on Aging should take the lead in directing state and local units on aging to gear Title III social and nutrituion services to those seniors who are "at risk," especially low-income older Blacks. AoA should direct the aging network to target substantially more services to elderly Blacks and other minority groups. Unless AoA gives this direction, the Black aged will continue to receive only what is left after local offices on aging distribute funds to serve those that they consider to be most deserving.

o Rationale: The 1978 Older American Act Amendments require state and area agencies on aging to provide assurances that social services will be targeted to older Americans with the "greatest economic or social needs." However, this mandate has been largely ignored by numerous area and state agencies. A directive from AoA is necessary to emphasize that this statutory requirement must be fulfilled.

o Recommendation: More centrally located service centers should be established for the delivery of the following services: geriatric care, transportation, preventive services, homemaker and home health services, nutrition, and case management. The nutrition program should be available seven days a week and holidays. Eligibility for transportation should be simplified by removing existing restrictions imposed by certain funding sources.

o Rationale: A one-stop center to deliver a wide range of comprehensive services is not only more convenient for older persons but also is more cost effective. Efforts are also needed to coordinate existing services programs to remove apparent and real incongruities.

o Recommendation: AoA should develop a closer working relationship with Black church, civic, and recreational groups in developing an effective social services strategy for older Black Americans.

o Rationale: Black church, civic, and recreational groups are an integral part -- along with Black Families -- of an informal network that provides services for older Black Americans. These groups must have input in developing a social services strategy to maximize the strengths of formal and informal support systems.

o Recommendation: Outreach programs should be given adequate funds to assure that services are reaching the targeted population. Area agencies on aging should provide technical assistance to outreach programs, and outreach workers should be located to facilitate their work in rendering services.

o Rationale: Many potentially eligible older persons never receive services for which they are entitled. Aggressive outreach is necessary to seek out, find, and certify those who are entitled.

o Recommendation: Federal funding for community day care programs should be increased.

o Rationale: Many older persons wind up in institutions simply because alternative care and services are unavailable. Community day care services can assist families who must work but do not want to place a relative in an institution because the relative may need some help to carry on day-to-day tasks.

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the 1981
White House
Conference
on
Aging

Report of
the Mini-Conference on
Pacific/Asian Elderly
"Pacific/Asians The Wisdom of Age"

MCR-42

Note: The recommendations of this document are not recommendations of the 1981 White House Conference on Aging or the Department of Health and Human Services. This document was prepared for the consideration of the Conference delegates. The delegates will develop their recommendations through the processes of their national meeting in late 1981.

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Pacific/Asian Elderly

In the decade since the 1971 White House Conference on Aging, we have seen the development of the Pacific/Asian community in its totality, and in the aging community specifically. The definition Pacific/Asian has evolved, which now includes 18 ethnic groups comprised of Pacific Islanders and Asian Americans.

With the inception of the National Pacific/Asian Resource Center on Aging, in 1979, the myriad of problems confronting the Pacific/Asian elderly have been more clearly delineated.

The underlying assumption and perpetuation of the myth that Pacific/Asian elderly do not have problems, and that we are able "to take care of our own" continues to pervade. Policy decisions of agencies and governmental entities continue to be fraught with this assumption. The translation of this assumption into attitudinal bias in delivery of services has further barred the Pacific/Asian elderly from much needed health and social services.

The information base regarding the Pacific/Asian elderly is lacking, obviating in the minimal responsiveness in developing relevant programs. The support for training of persons of Pacific Island or Asian ancestry is minimal; and the paucity of the hiring of Pacific/Asian persons in all areas of the aging network is glaring. The major scope of activity regarding "minorities" is generally directed toward the Blacks and to some extent the Hispanics.

Since the 1971 White House Conference on Aging, programs for the Pacific/Asian elderly have been generated by many community self-help groups. However, such services are not sufficient in numbers to meet the need. Limited access to funding, as well as uncertainty of funding have curtailed the development of such programs within the community. And yet, there is continued neglect by the generic service delivery systems to address the needs of the Pacific/Asian elderly population.

A review of the recommendations made to the White House Conference on Aging, 1971, reveal the continued neglect of the Pacific/Asian elderly in 1980. The efforts made to ameliorate the history of neglect are minuscule. Few of those 1971 recommendations have resulted in responsive policy decisions or legislation.

The emergence of the new immigrant groups since 1965 and the influx of the Indochinese refugees since 1975 is another social indicator of the inability of the society to deal with Pacific/ Asian elderly. Minimal attempts have been made to even identify the numbers of elderly in these populations. The programs such as English as a Second Language are only directed at the young adult population, those "capable" of participating in the job market. Lack of transportation and placement in communities with few or no support systems insure the elderly will not have access to services. Within the next five to ten years, the problems of the Pacific/Asian elderly will multiply if the neglect continues.

The Mini-Conference on the Pacific/Asian elderly, in preparation for the 1981 White House Conference on Aging, was designed to permit an intensive examination of particular national issues from the unique perspective of the Pacific/Asians and to increase the visibility of these issues. An example is the impact of aging upon minority elderly who have problems or needs that differ from those of the "majority" community.

This distinction first surfaced during the 1971 White House Conference on Aging in Washington, D.C. when minority delegates were belatedly assigned to special concerns sessions to discuss their particular issues. This response to the special problems faced by the minority elderly were somewhat ad hoc and, at best, permitted a venting of some frustrations but allowed little in-depth examination of the issues and provided no real opportunity for the views of the minority elderly to impact upon the other delegates at the conference.

Between March and July of 1979, the Pacific/Asian Elderly Resource Center Development Project, predecessor to the National Pacific/ Asian Resource Center on Aging, sponsored four regional workshops in areas with high concentrations of Pacific/Asian elderly: Chicago, Honolulu, New York City, and San Francisco. Participants included representatives of the Pacific/Asian elderly, service providers, members of community organizations, and others concerned with the Pacific/Asian elderly. A total of 446 individuals attended the four workshops, with approximately one-third being elderly.

These regional workshops proved extremely productive. Participants capitalized on an opportunity to explain and define specific policies and develop strategies which would facilitate improved access to and utilization of public health and social services by the Pacific/Asian elderly. The project not only laid the foundations for the creation of the National Pacific/Asian Resource Center on Aging, but bridged a common concern within Pacific/Asian communities nationwide for their elderly. This Mini-Conference, for the first time on a national basis, will direct the needs and concerns of the Pacific/Asian elderly to the White House.

THE PARTICIPANTS

Two-hundred fourteen individuals attended the Mini-Conference representing fourteen states of the mainland United States, Hawaii and the Pacific Jurisdictions of Guam and American Samoa. Thirteen out of over twenty Pacific Island and Asian ethnic groups were present: The Japanese community held the largest turnout comprising 44% of the total number of participants, followed by the Chinese at 19% and the Pilipinos at 16%. Other groups included Burmese, East Indian, Guamanian, Hawaiian, Korean, Micronesian, Okinawan, Samoan, Taiwanese, and Vietnamese. Black, Caucasian and Hispanic persons (6% total) were also in attendance.

Fifty-five percent of the participants were female. Participants ranged in age from 21 to 80 years, with an overall average age of 47. Thirty percent of the participants were 60 years of age or older, having an average age of 66 years. Seventeen percent were between the ages of 50 and 59 years.

A large portion of the elderly participants were retired performing work in a voluntary capacity. The most frequent occupation among all participants occurred in the areas of administration, management or coordination of social or health service programs (44%). The positions of social or health care workers (e.g. social workers and nurses) ranked second (42%). Other job titles included academician/researcher, accountant, attorney, board member, librarian, minister, and student.

THE PROGRAM

The Mini-Conference provided an arena for the development of national policy recommendations on those issues which significantly affect the Pacific/Asian elderly. The five issue areas considered were health care, economic security, social service, nutrition, and housing.

Unlike the general aging population who change in status primarily due to age, the Pacific/Asian elderly face problems which are, by degree and extent, greater. They have not been afforded equal opportunity to participate fully in this society as a young person. Therefore, their problems are cumulative and severely aggravated by age.

Although the White House Conference on Aging has identified a number of issue areas, it was decided by National Pacific/Asian Resource Center on Aging to focus on five issue areas for this Mini-White House Conference on Aging. The rationale for this decision was to maintain focus and to reaffirm the critical circumstances of the Pacific/Asian elderly. The state-of-the-art clearly demonstrates that the Pacific/Asian elderly continue to be an underserved population. Many of the other issues not addressed by this Mini-Conference are directed to a population which has enjoyed continued full participation in this society.

Each issue-area symposium was comprised of a panel presentation followed by small group discussions. Each panelist described the program or work with which she or he is associated, developed policy recommendations that address gaps in the delivery of services within the particular service area, and identified implementation strategies and mechanisms for those recommendations. A number of small discussion sessions then reviewed and evaluated the program and policy recommendations and implementation schemes presented by the symposium panel. Results of all discussions across the five issue areas were summarized into the recommendations presented in this report.

RECOMMENDATIONS

Research and Demonstration

It is recommended that:

* Federal funds in both areas be allocated to develop the information base on the Pacific/Asian elderly population. Such endeavors should be promulgated in the Pacific/Asian community or by Pacific/Asian researchers. The paucity of information and documentation of needs is glaring. In the last decade only one major national research effort has been funded to study the Pacific/Asian elderly population. The demographic information, morbidity and mortality rates are negligible. The research efforts should reflect the diversity of the Pacific/Asian groups. Specific program and service needs for the various groups must be identified and delineated.

* Long Term care demonstration efforts should include development of programs within the Pacific/Asian community

The National White House Conference Mini-Conference "Pacific/Asians: The Wisdom of Age" was organized and planned to focus on those unique problems and concerns.

Health Care

In certain groups of the Pacific/Asian elderly population, a high proportion are single males; a result of the enactment of legislation prohibiting immigration of Asians to this country.

Pacific/Asian elderly have not utilized entitlement programs such as Medicaid and Medicare. According to a study done in New York City Chinatown, 33% of the single males had never interacted with a public or voluntary social service agency.

We find high percentages of indivfduals in the "at risk" category. Many rely on folk medicine, friends and, if available, family. Consequently, the health problems are more debilitating and long term in nature.

It is recommended that:

* Title XVIII and XIX be expanded to include: (a) home health care; (b) differential eligibility criteria for Medicare/Medicaid programs; and (c) day health care.

* Legislation be enacted that will provide for the utilization of family/community support systems in the delivery of health care services by reimbursing individuals on a unit-cost basis.

* Within the provisions of Title XXI and/or related legislation, that the following be integral components: (a) integrated, comprehensive health care services which include non-medical support services; (b) the continuum of care include the development of board and care units; and (c) the non-medical components, e.g. senior centers be considered in the delivery of services.

* Legislation be enacted which would accommodate the allowance of foreign-accredited training in the health care field.

* In the development of health care legislation, a holistic approach which specifies the utilization of folk medicine be articulated.

* A national health care plan modeling the Health Maintenance Organization be enacted.

* Funding be allocated to enable the Pacific/Asian community to develop adult day care services within the community.

* In order to insure equanimity of access and utilization of services, that bilingual/bicultural staff be hired in non-indigenous service programs.

* Model projects and demonstration funding be earmarked for the development of a service program which would include the utilization of the family as a primary caregiver.

* Provisions be made to provide greater incentives for the recruitment of Pacific/Asian persons into the health care professions.

* Curriculum be developed and disseminated that will expand the knowledge base of Pacific/Asians in providing services to their elderly.

* Funding be allocated specifically for the purpose of training the Pacific/Asian elderly and their families around health care education.

* Cultural sensitivity and understanding be mandated as part of the training of generic service providers.

* Training funds be allocated to develop and expand the use of cultural approaches and remedies in the health care of Pacific/Asian elderly.

Economic Security

Although social security constitutes the mainstay of the elderly population, many of the Pacific/Asian elderly do not participate, or only minimally participate. Not because the Pacific/Asian elderly are well-endowed financially; quite the contrary. Pacific/Asian elderly populations largely tend to be below poverty or near-poverty levels. However, because of the nature of their employment which have not been included in this program or because of the transitory nature of their jobs, they have not had sufficient vesting opportunities. Many Pacific/Asian elderly groups have been employed in the secondary work force, in garment factories, in farming, or in restaurants. Their incomes many times are based on unit output, "piece-work".

The requirements are complicated; most of the Pacific/Asian elderly are monolingual in their respective languages. Materials have only been provided in English; and those individuals charged with the responsibility of carrying out this act have done very little to provide bilingual information or staff.

Private pension participation is non-existent in the Pacific/Asian elderly population. These plans have traditionally been available to those occupying the white collar, or union-covered jobs. These programs inherently are middle class in their job orientation. Such jobs have only been limitedly available to the now elderly.

Pacific/Asians generally have tended to remain in the work force longer than those in the larger aging population. This is necessitated by their lack of access to pension income. Often times they do so at a high cost to their own well-being.

It is recommended that:

* Provisions responsive to the needs of the Pacific/Asian elderly be enacted which include: (a) removal of ceilings of earnings by recipients of Social Security Insurance; (b) the utilization of general revenues as part of the financing mechanism for Medicare; (c) survivors benefits should be commensurate with those of the primary recipient; and (d) status quo regarding reference age as opposed to being raised to 68.

* E.R.I.S.A. be amended to provide mandatory pension plans to cover all those workers not currently covered.

* Under the Older American Act re-authorization of 1981, include in its language the targeting of services for minorities, e.g. Pacific/Asians.

* Provisions be developed that will change the vesting requirements of public and private pension programs.

* In the consideration of the expansion of adequate benefits to the poor and women for social security, income-sharing allowance be mandated for the non-working spouse.

* Under the Older American Act, Title V, that a national contract be awarded which would provide for manpower training of older Pacific/Asians.

* Agencies responsible for entitlement programs be affixed in community-based programs.

* Service delivery systems which continue to be unresponsive to the needs of Pacific/Asian elderly be mandated to hire bilingual/bicultural personnel.

* Funding be made available to provide technical assistance to the Pacific/Asian elderly in the utilization of entitlement programs.

* Technical assistance be provided to community support systems in the areas of public and private income resources.

Social Service

Social service in its broadest definition includes all those services which will allow for increased participation and access, i.e., transportation, outreach, information and referral, escort services, and language translation.

The Pacific/Asian elderly have relied on the informal support system for many of these services. However, this becomes increasingly difficult as families become mobile, ethnic neighborhoods disappear and financial capability is reduced. As well, with the constant reinforcement to become part of the large society "mainstreamed" many of the values and traditions break down.

Even as a "residual" system, social service institutions have not availed programs to the Pacific/Asian elderly. Only recently, and on a minimal scale, has the Pacific/Asian community created their own indigenous programs. This was out of necessity as the institutions were unresponsive leaving the Pacific/Asian elderly isolated and further alienated.

It is recommended that:

* Legislation which, within the entitlement programs, insures a broader-based definition of social services be enacted.

* In the re-authorization of the Older American Act in 1981, that provision be made which will re-establish the social service components cut by the 1978 re-authorization.

* Outreach mechanisms be developed which utilize the community support systems, e.g. informal support systems, churches, family associations, etc.

* Bilingual/bicultural personnel be recruited and hired by those agencies mandated to serve the elderly, e.g. area agencies and state units on aging and the Administration on Aging.

* The Pacific/Asian community-based programs which fit the criteria be designated as focal points under the Older American Act.

* Public transportation systems be required to develop plans that will access transportation to the Pacific/Asian elderly.

* Recreation programs be initiated and funded which will adhere to the cultural integrity of the Pacific/Asian lifestyle.

* Indigenous information and referral service programs continue to be funded and other generic agencies be required to hire bilingual/bicultural staff to maximize the dissemination of information.

* The area agencies and state units on aging be required to be trained in the culturally specific program modalities which will maximize participation of the Pacific/Asian elderly.

* Culturally specific tools be developed and disseminated by the formal aging network, e.g. Administration on Aging, area agencies and state units on aging.

* Training and educational institutions initiate a plan which will increase the participation of Pacific/Asian persons in the field of aging.

* The inservice programs for all generic agencies include training on the Pacific/Asian elderly.

* The area agencies and state units on aging be required to provide specific training on the Older American Act to the Pacific/Asian community.

Nutrition

Since the inception of the Older American Act, 1965, the participation of Pacific/Asian elderly in the generic nutrition programs is minimal. The deficit of the program generating from the assumption everyone eats the same food and that ethnic consideration regarding food is neglected.

In the last decade, we have seen the emergence of a few indigenous nutrition programs. The demand for such services are far greater than the available resources, documenting the reality that the Pacific/Asian elderly would use and need such services. However, they must be ethnic specific and culturally relevant.

It is recommended that:

* Regulatory agencies amend the guidelines and regulations to accommodate the inclusion of ethnic-specific food service delivery.

* Entitlement programs provisions specify nutritional standards which recognize the dietary and nutritional standards of Pacific/Asian foods.

* Funding be earmarked for more bilingual/bicultural indigenous service contractors.

* Funding reflect the per capita cost of the higher costs of ethnic foods.

* The component of home-delivered meals to the isolated and frail elderly be expanded.

* The support services (transportation, etc.) provisions be expanded under Title III of the Older American Act.

* Funding allowances be expanded to train bilingual/bicultural persons to provide nutrition programs to the Pacific/Asian elderly.

* Those agencies responsible for funding direct services be required to be trained on the cultural and dietary difference in needs of the Pacific/Asian elderly.

Housing

In constructing national policies for the development of a housing continuum, consideration should be made for reestablishing and reinforcing the family and informal support systems. Within the Pacific/Asian community, it is still feasible to design such a compendium; the values and traditions are sufficiently intact and lend themselves to such a development.

It is recommended that:

* Legislation be enacted that would accommodate the development of housing which supports the maintenance of family support systems (i.e. two-family dwellings, duplexes).

* Provisions for the inclusion of supportive services be incorporated into legislation.

* Tax incentives be provided for the renovation of existing dwellings as well as expansion to allow alternatives for the Pacific/Asian elderly.

* Funding be maintained and further expanded for Congregate Housing Programs.

* Technical assistance be provided the Pacific/Asian community by HUD for program development.

* Bilingual/bicultural personnel be hired and deployed to work with the Pacific/Asian community.

- * Needs assessment required to determine program development for the Pacific/Asian elderly.

- * The development of a continuum of care in housing be funded in those communities serving Pacific/Asian elderly.

- * That the Pacific/Asian community service providers be trained in the rules and regulations regarding housing development.

- * That culturally specific components be integrated into training programs for staff of HUD.

- * Materials and information packets be developed on various Pacific/Asian languages for the purpose of dissemination and education.